St. Nicholas School Contact & Emergency Information Form

IDENTIFYING INFORMATION			EMERGENCY CONTACT INFORMATION		
Student's Name:			***In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:***		
Birthdate:	Grade:		**Call 1st:**	Name:	Home/Work Phone:
Parent (Guardian) Names:				Relationship:	Cell: Phone:
Address Street:			**Call 2nd:**	Name:	Home/Work: Phone:
Address Apartment No./Other:				Relationship:	Cell: Phone:
Address City:	State:	ZIP:	**Call 3rd:**	Name:	Home/Work: Phone:
Home Phone:	E-mail Address:			Relationship:	Cell: Phone:
Child lives with: ☐ Mother and Father ☐ Mother ☐ Father ☐ Grandparent(s) ☐ Guardian			Local Hospital of Choice:		
Who is the Custodial Parent (if applicable)?	☐ Custody Papers on file?		Physician of Choice:	Phone:	
Siblings attending this (*school, program, event*):			**HEALTH INSURANCE INFORMATION**		
Adults who are authorized to pick up my child:	Name:	Phone No.	Company:	Co. Phone:	
			Policy Holder	Group No.:	
			Holder ID No.:	Plan No.:	
			Policy No.:	Patient (Child) ID No:	

MEDICAL INFORMATION

Child's Medical-Conditions:	Please list below any medical conditions your child has such as chronic or serious illness; severe allergies or sensitivities including, but not limited to: food, medicine, insects, or heat; asthma; cancer; diabetes, heart condition; respiratory problems; seizures, urinary problems; hemophilia; frequent hospitalizations; vision or hearing difficulties, physical limitations, etc. ☐ Individual Health Plan for chronic conditions on file (if applicable)	**Medications Taken-Regularly by Child:**	Please list below any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know about at the time of treatment for illness or injury. ☐ Medication Release on file for all medications taken at St. Nicholas School.

CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD

I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact me/us as specified above *before* authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of St. Nicholas School to act on my/our behalf, to call 911 emergency services, transport by ambulance, hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and with treating medical personnel.

Notice is hereby given to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I/we agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.

Parent/Guardian Signature(s): **Relationship(s):** **Date:**

St. Nicholas School

PARENT/GUARDIAN RELEASE
SELF-ADMINISTRATION OF MEDICATION

Archdiocese of Indianapolis Policy Statement 2008-02 recognizes that parents (guardians) have the primary responsibility for the health of their children. Although it is strongly recommended that medication be administered in the home, the health of some children and youth may require that they receive medication or other medical care while in the care of St. Nicholas School.

If a student must take medicine while at school, please be advised of the following:

- ✓ Parents (guardians) should confer with their medical practitioner to arrange medication intervals to avoid administration of medication outside the home whenever possible.
- ✓ When medication absolutely must be taken at other times outside the home, parents (guardians) shall provide explicit written instructions including, in some cases, instructions as necessary from a medical practitioner regarding the need for medication or specific medical care.
- ✓ Parents (guardians) signing this form are, in most cases, providing written permission for **non-medically trained personnel** to oversee the **self-administration** of medication or necessary routine medical care **by the student** depending upon age and capability.
- ✓ Medical circumstances requiring the direct measuring and/or administration of medications, injections, blood tests, observation of symptoms, specific emergency responses by non-medically trained staff personnel or the possession and use of inhalers or other medical devices, shall be handled on a case-by-case basis according to a specific Individual Health Plan developed and signed by a physician or other health care professional and kept on file for the student.
- ✓ Students are not permitted to carry medications (including analgesics, herbs, enzymes, oils, etc.) on their persons, except for inhalers and other medical devices with specific permission. Medications will be secured in the office.
- ✓ All medication is to be delivered and taken home by the parent (guardian) at the end of the medical regimen or school year.
- ✓ All medication is to be taken in the presence of a designated staff member and documented in a confidential log.
- ✓ **No medication** of any kind is to be provided by the school, staff or volunteer personnel.
- ✓ Prescription medication must be in the original pharmaceutically dispensed and labeled container. The prescription label will be considered the written order of the medical practitioner in most cases.
- ✓ Non-prescription medication must be in the original container in which it was purchased. Please provide medicine cups/spoons as necessary for liquid medication.
- ✓ Parents must fill out, sign and date a new form for each medication or to change medication instructions.
- ✓ All medication releases must be renewed at the beginning of each school year.

Please provide specific written instructions below for administration of medication during school hours:

Name of Student:	
Name of medication: ☐ Prescription ☐ Non-Prescription ☐ Refrigeration Required	
Diagnosis/reason the medication is to be taken:	
The appropriate dose, method of administration (i.e., by mouth) and specific instructions (i.e., take with food, etc.):	
The time or times of day (hours) medication should be taken in our care:	
The start date and number of days/weeks/ months the medication is to be taken:	
Any known side-effects of the medicine and/or symptoms of the condition being treated and known tolerance to medicine:	

I hereby give permission for non-medical staff personnel to oversee self-administration of the medication specified above by my child:

Parent (Guardian) Signature: _____ Date: _____ Emergency Phone No: _____