

HOLY FAMILY SCHOOL Medical / Emergency Form

STUDENT NAME: _____ **Date of Birth:** _____

Mother: _____

Cell Number Home Number Work Number

Father: _____

Cell Number Home Number Work Number

Emergency Contact: _____

Cell Number Home Number

List any Severe Illnesses:

Drug Sensitivity: _____ **Other Allergies:** _____

Food Allergies: _____

Please circle any medical condition(s):

ASTHMA CARDIOVASCULAR MIGRAINES DIABETES ORTHOPEDIC _____

SEIZURES GASTROINTESTINAL OTHER: _____

MEDICATION – List the name & reason for medication your child is currently receiving including medication taken at home. For additional medications, please attach list a separate listing.

Name of Medication Dose Time Reason

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Parent/Guardians are responsible for providing to the school nurse all prescription medications needed for his/her child. **All medications, including over-the-counter medications,** must be provided in the original container or package, labeled with the student's name and accompanied by a **physician's order**.

At School my child may be given the following (please check and initial medication you authorize):

_____ **Tylenol** _____ **(initial)** _____ **Benadryl** _____ **(initial)**

_____ **Antacid** _____ **(initial)** _____ **Advil** _____ **(initial)**

As the parent or guardian, I release Holy Family School and the Phoenixville School District, its officers, agents, and employees from all claims or liabilities of any kind arising out of the dispensing of medication to the student pursuant to the authorization granted herein.

POTASSIUM IODIDE CONSENT (Please circle one.)

YES I DO give consent for my child to be given potassium iodide (KI), when instructed by public Health officials, in the event of a radioactive emergency during school hours.

NO I DO NOT give consent for my child to be given potassium iodide (KI), when instructed by public Health officials, the event of a radioactive emergency during school hours.

MEDICAL AUTHORIZATION AND CONSENT:

In the event of an emergency which would require medical care and treatment to be administered to the student. I/we hereby authorize any physician, hospital or other health care provider to give emergency medical care and treatment to this student. The undersigned have read this Medical Authorization Consent Form and declare and affirm that I/we consent to the consents herein stated.

Parent/Guardian – Please Print

Parent/Guardian Signature