Medical Information Form

(Required for any student requiring medication or medical attention)

Student's Name: _____ **Date of Birth:** _____

Health Insurance Provider and Medical Plan # _____

Parent/Guardian's Name: _____ **Contact Number(s):** _____

Doctor's Name & Phone Number: _____

Emergency Contact Name & Phone Number: _____

List any ailments, disabilities or problems involving your child which may affect her/her participation.

Allergies (Food)_____ Allergies (Seasonal)_____

Asthma _____ Diabetes _____

Epilepsy _____ Other _____

Information sponsors should be aware of:

1. Unusual reactions or allergies to medication?_____
2. Special care needed while on activity?_____
3. Special instructions to medical personnel if emergency care is needed?_____
4. Significant health problems? _____

An employee trained to administer medication must accompany students needing prescribed medication during field study hours. All medications (prescription and over-the-counter) must have an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic. All medications must be received in the original container with the current Rx label including student's name, dosage, frequency of administration, physician's name and expiration date of the medication (the expiration date on the pharmacy label, not on the medication box, will be the expiration date). Over-the-counter medications must be in the original, unopened container. EXCEPTION: Students at the middle and high school level may carry a non-prescription, non-emergency medication on his/her person while in school with written permission from the parent/guardian. A copy of the signed permission form must accompany the stated medication at all times.

Name and purpose of medication: _____

How it will be given: _____ Time to be given:_____

Parent/guardian's signature: _____

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the activity supervisor provide treatment for my child named above.

Parent/guardian's signature: _____

Date: _____