SMCDS Medical Information and Authorization

Date

Student's Name: _____ _____ _____ _____ _____

Last First MI Date of Birth Grade

Home Address: _____ _____ _____ _____

Street City State Zip Code

MEDICAL INFORMATION:

Allergies _____ **Asthma** ☐ **Inhaler in School?** ☐ **Epi-Pen?** ☐

Operations, Injuries _____ **Vision: Glasses** ☐ **Contacts** ☐

Medical Condition(s) _____

Dental Exam Yes ☐ **No** ☐ **Date** _____

MEDICATION: (Please indicate if the student takes any medication on a regular basis. List the name and dosage of the medication.)

(1) _____ **(2)** _____ **(3)** _____

MEDICAL INSURANCE INFORMATION:

Medical Insurance carrier _____ **ID/Policy#** _____

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT AND RELEASE

As the parent or guardian of _____, a St. Michael's Country Day Student, I hereby authorize and consent in the case of accident or illness to any and all treatment, surgery or medical assistance of any kind deemed necessary or desirable by officials or employees of St. Michael's Country Day School, or by any other physicians or medical personnel. I understand that St. Michael's Country Day School shall make reasonable efforts to contact _____'s parent(s) or guardian before arranging for or providing emergency medical assistance, except when immediate attention is necessary.

I assume responsibility for all medical expenses incurred on behalf of the student.

_____ _____

Parent or Guardian (Signature) Date

I give my permission for the School to administer: (please check desired over the counter medications**)**

Tylenol (pain reliever**)** ☐
Benadryl (antihistamine) ☐
Tums (antacid) ☐
Ibuprofen (anti-inflammatory) ☐
Cough Drops ☐
Mucinex (Cough Suppressant/Expectorant**)** ☐
Mucinex Cold Medicine ☐