St. Michael's
COUNTRY DAY SCHOOL

# Medical Information and Consent to Treat

Grade: ___________

Student Name: ____________________ ________________ _____ Date of Birth: _____________
Last First MI

Home Address:_______________________________________________________________________
Street City State Zip Code

Parent/Guardian Contact #1: ____________________________________________________________
Name Relationship to Student Best Contact Phone #

Parent/Guardian Contact #2:____________________________________________________________
Name Relationship to Student Best Contact Phone #

Emergency Contact if Parent(s) unavailable:______________________________________________
Name Relationship to Student Best Contact Phone #

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**MEDICAL INFORMATION: Please fill in COMPLETELY below; check appropriate boxes**.
If your child has asthma, severe allergies, and/or a chronic medical condition, have your doctor provide an **Emergency Action Plan** *signed by both physician and parent/guardian*.
**Allergy(ies)**______________________________EPI-pen in school? [ ] **Asthma** [ ] Inhaler in School? [ ]
Chronic Medical Condition(s) or Concerns; Recent operations or injuries______________________________
___________________________________________________________________________________

MEDICATION: Please indicate if student takes any medication on a regular basis, including medication name and dosage.
1.________________________ 2.____________________________ 3.__________________________

Student's Doctor: ____________________________________ ***Date of last physical exam***:_______________
VISION: Glasses [ ] Contacts [ ] Date of last Comprehensive vision exam:_________________
***All Kindergartener's must receive a comprehensive eye exam before September 30th, 2018.
DENTAL: **Name of Dentist**:________________ ***Date of last dental exam***:_____________________

MEDICAL INSURANCE INFORMATION
Insurance Provider:__________________________________ ID/Policy #________________________

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## AUTHORIZTION FOR EMERGENCY 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 emergency treatment deemed necessary for the safety and well being of the above student, by officials or employees of St. Michael's Country Day School and physicians / medical personnel engaged to provide emergency treatment, including any surgery deemed necessary by medical professionals. I understand that St. Michael's Country Day School shall make reasonable efforts to contact 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: (Print) (Signature) Date

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# Medication Administration

Student Name: ________________________________________ Date of Birth:__________________

Per standing orders from our school physician, Dr. Catherine Labiak-Maher, the school nurse is able to give Acetaminophen and/or Ibuprofen up to 10 times in the school year, as needed, with your signed permission below.

More than 10 doses of Acetaminophen, or Ibuprofen, and **ANY** other medications, prescription or over-the-counter, must be accompanied by doctor's signed order prior to medication administration. (The school nurse is not able to give antihistamines, cough medicine, allergy medications, etc. –even over the counter- without your doctor's signed orders.) If your child will need these medications it is best to provide them before school hours or provide orders from the doctor to enable the school nurse to administer.

SMCDS supplies Acetaminophen and Ibuprofen. ALL other medications sent to school must be delivered in original packaging (no plastic baggies with medications please) and accompanied by doctor's orders.

**I give my permission for the school nurse to administer Acetaminophen and/or Ibuprofen, up to 10 times each, as needed, for illness or injury during the 2018 -2019 school year.**

**Acetaminophen** (pain reliever) [ ] and/or **Ibuprofen** (anti-inflammatory, pain reliever) [ ]
**OR: NO Meds [ ]** *I understand that in checking this box, the school nurse will not be able to provide any medications to my child without a signed written reversal of this request.*

Every effort will be made to contact parents prior to administering medications. If you DO NOT want medications given without your verbal permission, in addition to this signed form, please indicate below:

[ ] Wait. Do not administer medication without verbal consent, **in addition to this signed form.**

OR

[ ] Yes, administer the above indicated medications for headache, pain/discomfort, or inflammation, as needed, even if unable to reach me by phone ahead of time. Contact me with complete details: reason given, medication, dose, form, and time given, as soon as possible.

_________________________________/_________________________________ ________________
Parent or Guardian: (Print) (Signature) Date

Do not write below this line; for office use.

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Acetaminophen 1 2 3 4 5 6 7 8 9 10
Date given:

Ibuprofen: 1 2 3 4 5 6 7 8 9 10
Date given:



Revised 2018