St. Michael's COUNTRY DAY SCHOOL

Medical Information and Consent for Treatment

Student Name: _____ _____ ____ Date of Birth: _____ Grade: _____
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 #

MEDICAL INFORMATION

Allergies_____. **Asthma** Inhaler in School? EPI-pen?

**If your child has Asthma or serious allergy requiring EPI pen and/or Benadryl, please have your doctor provide an Emergency Care Plan signed both by physician and parent/guardian. Examples of these 2 documents can be found on SMCDS website: Health Forms.

Operations/Injuries_____ Vision: Glasses Contacts

Medical Condition(s) or Concerns_____

MEDICATION: Please indicate if student takes any medication on a regular basis, including medication name and dosage.

1. _____ 2._____ 3._____

Name of Pediatrician:_____ Contact Phone #:_____

DENTAL Exam: Yes No ***Date of last exam***:_____ Name of Dentist:_____

MEDICAL INSURANCE INFORMATION

Insurance Provider:_____ 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

Above signature also applies to permission for SMCDS to administer the following over the counter medications up to 10 times in the school year. Any other medications, prescription or over the counter, will need to be supplied by a parent in the original container and accompanied by a Short Term Medication Administration Form that is signed by a physician.

Please call parent/guardian prior to any medication administration: Yes No

Tylenol (pain reliever) **Ibuprofen** (anti-inflammatory) **Cough Drops**