

Medical Information Form

Parish/School _____

Date: _____

Student: _____ Date of Birth: ___/___/___/ Age: ___ Sex: ___
(Last Name) (First Name) (Initial)

Address: _____ City: _____ Zip: _____ Grade _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contact: _____ Phone: _____

Permission for Prescribed Medication

Reason for Medication: _____

Name of Medication: _____ Form: tablet/capsule/liquid/inhaler/injection/nebulizer
Other: _____

Instructions (schedule and dose to be given at function): _____

Start date: _____ End date: _____ other: _____

Restrictions and/or important side effects: _____

Special Storage requirements: _____

Student may carry medication: ___yes ___no

Student is both capable & responsible for self-administering medication ___yes ___no

Unsupervised ___Yes-Supervised

Other Information:

Date of last Tetanus Booster: _____

List any allergies: _____

List any medications being taken at this time: _____

List any medical conditions/pertinent health information we should be aware of: _____

Release:

In case of an emergency I hereby give my permission to transport my child to a hospital for emergency medical or surgical treatment. Payment for medical emergencies is the responsibility of the parents/guardians.

Signature of Parent/Guardian: _____ Date: _____

Insurance Information:

Insurance Carrier: _____ Policy Number: _____

I give permission for (name of child) _____ to receive the above medication at the program according to this medical information form.

Signature: _____ Date: _____ Relationship: _____