Student Emergency, Health and Medication Form

Students' grade level for this year:	(circle one) K 1 2 3 4 5 6 7 8 9 10 11 12
Students' Name:	Students' Date of Birth:
Home Address:	Home Phone:

Parent/Guardian:	**Cell:**
	Work:
Parent/Guardian:	**Cell:**
	Work:

Medical History

Does this student have any of the following conditions: (Check all that apply)

☐ Asthma ☐ Anxiety
☐ Seizures ☐ Heart Condition
☐ Diabetes ☐ Hearing Loss
☐ Migraines ☐ Vision Problems

Please describe any conditions I need to be aware of to care for your child:
_____
_____
_____

Does this student have a food, latex, or other Allergy? ☐ Yes ☐ No If yes, list _____

Has this student ever had chicken pox? ☐ Yes ☐ No If yes, when? _____

Daily Home Medications:

Daily School Medications:

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost. In the case of an accident or illness where immediate treatment of my child is not indicated, but where he or she is unable to remain at school, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that one of the other persons listed on this card be contacted and requested to care for my child. In the event no person designated on this care is available, emergency medical services may be contacted for further assessment and possible transport and treatment. I understand that certain educational records of my child will be shared with Success/Career Academy healthcare partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by SA/CA healthcare personnel at SA/CA may be shared with school officials who have a legitimate educational purpose for accessing such records.

Parent/Guardian signature: _____ _____
Signature of Parent/Guardian Date

CONSENT FOR OVER-THE-COUNTER MEDICATIONS TO BE GIVEN AT SCHOOL
(Only valid if Parent/Guardian checks off and signs below)

I give permission for _____ to receive the following medication:
(Student's Name)

Tylenol or Ibuprofen, dose per weight, every 6 hours as needed for minor pain. □ YES □ NO
Please notify me when my child takes Acetaminophen at school: □ YES □ NO

Antacid (Tums), 420mg tab, chewed, every 2 hours as needed for acid indigestion. □ YES □ NO
Please notify me when my child takes Antacid at school. □ YES □ NO

Cough Drops, 1 every 2 hours as needed for cough/minor throat irritation. □ YES □ NO
Please notify me when my child takes Cough Drops at school: □ YES □ NO

Parent/Guardian signature: _____ _____
Signature of Parent/Guardian Date

Success Academy
Jill Lehman RN
3408 Ardmore Trail
South Bend, IN 46628
Phone: (574)288-5333 Ext. 2018
Fax: (574)288-5388

Career Academy
Tracy Smith RN
3801 Crescent Circle
South Bend, IN 46628
Phone: (574)299-9800 Ext. 1104
Fax: (574)288-6125