NEAR NORTH MONTESSORI SCHOOL

MEDICAL FORM 2019-20: Authorization, Release and Medications Administration

Student Name:		Date of Birth:		Teacher:		Grade:	

One form is required for each Student; do not combine children from one family on a form. Authorization, release and consent executed here will be in effect while Student attends Near North Montessori School ("NNM") during the 2019-2020 school year. In addition to completing these forms, please make sure emergency contact information is updated in My BackPack.

MEDICAL RELEASE AND TREATMENT AUTHORIZATION

_____ (Parent/s or Legal Guardian/s name/s), as parent/s or legal guardian/s of the Student named above ("Student"), I/we understand that NNM offers limited student emergency and nonemergency medical services and treatment through the School Nurse and other trained staff. I/We hereby authorize such emergency and non-emergency medical services and treatment for Student as may be deemed necessary or appropriate by NNM faculty and staff, and that NNM will make reasonable attempts to notify me/us as soon as possible of injury or illness to Student. If NNM is unable to reach me/us, I/we authorize and give consent to the health authorities of NNM or licensed physician in emergency situations to perform upon or administer to Student, any reasonably necessary medical treatment and if necessary to transport Student to a hospital for care. If NNM or hospital staff are unable to reach me/us, I/we also give permission to perform any reasonably necessary emergency medical and surgical treatment and to administer anesthetic for Student that may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover first aid and emergency medical treatment for injuries or illness that occur during Student's attendance at NNM, which may include care by a school nurse, local physician(s), and /or local hospital and hospital staff. If the medication administration section is submitted for Student, then I authorize NNM to administer such medication to Student in accordance with the form.

In consideration of Student's enrollment at NNM and participation on class trips and on behalf of myself/ourselves, my/our personal representatives, my/our heirs, my/our assignees and my/our child, I/we: (a) waive and release any and all claims against NNM, and its Trustees, officers, directors, agents, representatives and employees – including but not limited to the Nature's Classroom and Nations Classroom and other organizations involved in school-sponsored trips and their representatives - in both their personal and professional capacities (collectively also "NNM Personnel"), for injuries, liabilities, losses or damages connected with or arising out of the rendering of medical or surgical treatment or the administration of medication to Student as ordered by a licensed physician, nurse practitioner or physician assistant on the medication administration section; and (b) shall indemnify, defend and forever hold harmless NNM and NNM Personnel from and against any and all claims, proceedings, injuries, liabilities, losses, damages, and expenses, including reasonable attorneys' fees and costs, relating to the rendering of, and transporting for medical treatment of Student.

I/We have read and understand the contents of this statement and confirm that I/we are signing this statement as my/our free act.

_____ _____

Parent/Guardian's Signature Date Parent/Guardian's Signature Date

_____ _____

Parent/Guardian's Name – Printed Parent/Guardian's Name – Printed

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Return all completed forms to Veronica Smith, School Nurse

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Student Name:		Date of Birth:		Teacher:		Grade:	

Student's Insurance Company: _____

Insurance Group #: _____

Insurance ID #: _____

STUDENT MEDICAL INFORMATION - *The information provided will be treated as confidential and shared only with NNM personnel as necessary. Information below will help us best assist your child in an emergency, please complete fully.*

Does Student have any:

Pre-existing conditions?	YES	NO
Dietary restrictions or known food allergies?	YES	NO
Other known allergies to medication, plants, animals, etc.?	YES	NO

If YES to any of the above questions, please explain:

_____

Has Student ever had:

A major surgical operation or been advised to have one?	YES	NO
Treatment in a hospital or institutions?	YES	NO
A major injury, surgery, or illness?	YES	NO

If YES to any of the above questions, please explain:

_____

Is Student currently undergoing treatment or taking medication? YES NO

If YES, please explain – check the box below for additional medication form if applicable:

_____

Provide any other important medical information or special accommodations

_____

If medication is required or authorized for Student (including over-the-counter medication) at school or during school-sponsored trips **the medication administration form must be completed.**

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MEDICATION ADMINISTRATION

TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

Indicate the medications approved to be administered to Student named above at school and while at school-sponsored trips or events.

Medication History

- ❑ No Daily Medications
- ❑ Medications to be Administered Daily at School or Camp
- ❑ Medications on an as needed basis

Student Information

Weight: _____

Height: _____

Student's weight and height will be used to determine appropriate dosage of OTC medications, unless noted differently in the OTC table below

List of NNM Stocked Medications

select items the student may be given:

- ❑ Acetaminophen (Tylenol)
- ❑ Ibuprofen (Advil, Motrin)
- ❑ Diphenhydramine (Benadryl)
- ❑ Antacids (Tums)
- ❑ Hydrocortisone 1% cream
- ❑ Topical antibiotic cream
- ❑ After bite

Other Over-The-Counter Medications: list approved OTC medications not listed above; examples include vitamins and allergy medications

OTC Medication/s	Dose	Route	Frequency/Time of Day

Prescription Medications: Including but not limited to epi-pens, antibiotics, behavior modifying medications, and inhalers

Prescription Medication/s	Dose	Route	Frequency/Time of Day

Parent/Guardian Signature/s: _____ Date: _____

Parent/Guardian Name/s (Printed): _____

PRACTITIONER AUTHORIZATION (Required for any medication, including over the counter medications)

Practitioner Signature: _____ Date: _____

Printed Name of Practitioner: _____ Phone Number:_____

Office Address: _____

Return all completed forms to Veronica Smith, School Nurse