JOSEPHINUM ACADEMY
OF THE SACRED HEART

MEDICAL CONSENT FORM

Student's Name _____ Date of Birth _____

A partnership with Josephinum Academy and Presence Health Care Saints Mary and Elizabeth Medical Center Nazareth Family Center has been established to assist students to meet the necessary State of Illinois Health regulations, as well as, address other health and welfare concerns.

I hereby agree to participate in the Josephinum Academy Health Program. This permission includes the authority to make decisions in the case of an emergency. I, legal guardian, hold Josephinum Academy, harmless against any and all claims or other forms of liability, which may exist with respect to providing the following services.

My agreement includes the following:

1. Health Questions/Concerns: My student may visit the nurse and/or physician at Josephinum Academy if she has health questions or concerns.

2. Health Screening: My student may participate in routine health screening.

3. Emergency Care: When a condition requires immediate intervention (e.g., first aid, asthma attack, seizure, vomiting), I give permission for my student to be treated in the event that I am not available to be reached.

4. Health Risk Survey: I want my student to be given the opportunity to participate in a Youth Risk Behavior Survey administered to grades 9-12 by Josephinum Academy. Participation in this survey is voluntary and the student anonymity is assured. Also, I understand that this survey is used to focus the school's health curriculum and programs.

5. Duration of Consent: The consent applies for the years that my student attends Josephinum Academy. Should I change my decision regarding the above, I will notify the school as soon as possible in writing. I will also notify the school if I am no longer the legal guardian of this child.

Guardian's Name _____ Guardian's Signature _____ Date _____

JOSEPHINUM ACADEMY
OF THE SACRED HEART

MEDICAL CONSENT FORM

_____

Student's Name

PLEASE LIST ANY ALLERGIES & REACTIONS:

_____

_____

List other medications your child receives regularly (All medicines should be stored in the Front Office)

MEDICATION NAME	DOSE	FREQUENCY

Please check if you would like the following medications to be available to your child during school and administered in the Front Office:

_____ Acetaminophen (Tylenol) _____ Ibuprofen (Motrin)

_____ Allergy Medicine _____ Tums

_____ Cough Drops

or

_____ I do not want any medication given to my child in school by the Front Office.

TO BE COMPLETED BY GUARDIAN:

I assure that my student, _____ has been given the above checked
(Name of student)
medications previously without adverse effects.

I give my permission for the school designee to administer the above checked medications, as prescribed, to my child as named above. I understand that generic equivalent medications may be used.

_____

Guardian's Name Guardian's Signature Phone Number Date