Medical and Emergency Information, Medication Authorization, Release, and Waiver Agreement

STUDENT NAME: _____
First Name Last Name

ENTERING GRADE: _____

The undersigned parents/legal guardians ("Parents") of the student named above ("Student"), a student attending Verbum Dei High School ("School"), hereby affirm(s) that all information provided on this Medical and Emergency Information, Medication Authorization, Release, and Waiver Agreement ("Agreement") will be complete, true, and correct, agree(s) to immediately provide School with updated information by telephone and in writing if any of the information provided by Parents or Student's physician on this Agreement changes, and agree to the following terms and conditions as set forth below. Parents and School are sometimes referred to herein individually as "Party" or collectively as "Parties."

STUDENT MEDICAL INFORMATION:

Primary Physician: _____

Primary Physician Address: _____

Primary Physician Phone Number: _____

Preferred Hospital: _____

Preferred Hospital Address: _____

Preferred Hospital Phone Number: _____

Dentist: _____

Dentist Address: _____

Dentist Phone Number: _____

Health Insurance Carrier: _____

Group Name/Number: _____

Policy Number: _____

Primary Insured: _____

ALLERGIES AND RESTRICTIONS:

Allergies to Medications: Please list Student's known allergies to over-the-counter, prescription, or other medications (if none, please write "none"):

_____

_____

_____

_____

Allergic Reactions: Please list Student's known allergic reactions that require medication or immediate medical attention (if none, please write "none"):

_____

_____

_____

_____

Restrictions: Please describe any restrictions Student may have that may impact Student's ability to participate in School and School-sponsored field trips, activities, athletics, and events held before, during, and after the school day (if none, please write "none"):

_____

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OVER-THE-COUNTER AND PRESCRIPTION MEDICATION AUTHORIZATION:

Parents understand and acknowledge that:

- All medications that Student may need to take during the school day or while Student is participating in School sponsored field trips, activities, athletics, and events held before, during, and after the school day, must be listed in this Agreement;

- All medications, whether over-the-counter or prescription, except those which must be kept on Student's person for emergency use, will be secured in the front office and dispensed by authorized School personnel; and

- Parents must provide more than the required dosages of any over-the-counter or prescription medication in case of an emergency.

Authorization to Administer Over-The-Counter Medications to Student as Needed:

The School maintains a basic supply of over-the-counter medications ("OTC"), listed below, on site to administer to students on an as needed basis during the school day and while students are participating in School sponsored field trips, activities, athletics, and events held before, during, and after the school day. Parental consent is required before School may administer OTC medication(s) to Student.

Please review the list below and mark "Yes" or "No" as to each OTC medication. Parents may discontinue or change their authorization at any time by contacting the front office and revising this form in writing.

All medications will be administered in the recommended age/weight-appropriate dosages as indicated on the medication label and by the manufacturer.

Yes	No	Over-The-Counter Medication
		Acetaminophen - Tylenol
		Ibuprofen – Advil/Motrin
		Aspirin
		Antibiotic Ointment – Neosporin, Polysporin
		Eye Drops
		Topical Creams for Minor Injuries – Hydrocortisone cream

Authorization for School to Administer Prescription Medication to Student:

Parents hereby request and authorize School to administer the following prescription medications identified below to Student according to the below schedule and directions during the school day and while Student is participating in School sponsored field trips, activities, athletics, and events held before, during, and after the school day.

Parents agree to provide School with the prescription medication in the original container with the pharmacist's label, which includes Student's name, medication name, amount (dosage), and time schedules. Parents agree that it is Parents' responsibility to provide School with unexpired and properly labeled doses/supplies. Parents acknowledge and agree that Parents will immediately notify School by telephone and in writing of any changes in Student's prescription medication needs and understand that a revised, written physician's authorization must be submitted. Parents authorize School to consult with Student's physician/medical provider regarding any questions related to Student's medication/supplies.

Parents acknowledge that Student must not share the medication/supplies with others and that Student and Parents must adhere to all School procedures and rules concerning the handling and administration of medication supplies

The following portion is to be completed by the prescribing physician:

Name of Medication:_____

Dosage:_____

Administration Method:_____

Directions/Time Schedule:_____

Special Instructions:_____

Name of Medication:_____

Dosage:_____

Administration Method:_____

Directions/Time Schedule:_____

Special Instructions:_____

(Include additional pages as needed)

I affirm that the Student for whom this medication is prescribed is under my care.

_____	_____
PRINT Name of Physician	SIGNATURE of Physician
_____	_____
Physician's Street Address	Telephone
_____	_____
City/State/Zip Code	Date

Authorization for Student to Carry and Self-Administer Prescription Medication During the School Day and During School-Sponsored Field Trips, Activities, Athletics, and Events:

☐ Check here if Student **does not** require self-administration of any prescription medications during the school day or while Student is participating in School sponsored field trips, activities, athletics, and events held before, during, and after the school day.

Parents understand that, in general, School does not permit students to carry or self-administer medications, unless a medical need exists for the student to carry or self-administer medication in connection with a serious health condition or illness that cannot be accommodated reasonably by allowing authorized School personnel to administer the medication. Parents understand that School shall review requests to carry and/or self-administer medication on a case-by-case basis and the Principal or designee must approve requests in writing.

Parents authorize Student to carry and self-administer the medication(s)/supplies listed in this section below, which Parents have marked for Student to carry and self-administer. Parents agree that it is Parents' responsibility to provide Student with unexpired, properly labeled doses/supplies and to train Student to administer/use the medication(s)/supplies without supervision by School personnel. In the event that Student is unable to administer the medication(s)/supplies without assistance, Parents agree that authorized School personnel will assist Student. Parents acknowledge and agree that Parents will immediately notify School by telephone and in writing of any changes in Student's medication needs. Parents authorize School to consult with Student's physician/medical provider regarding any questions related to Student's medication/supplies.

Parents acknowledge that Student must not share the medication(s)/supplies with others and that Student and Parents must adhere to all School procedures and rules concerning the handling and administration of such medication(s)/supplies.

The following portion is to be completed by the prescribing physician:

Name of Medication:_____

Dosage:_____

Administration Method:_____

Directions/Time Schedule:_____

Special Instructions:_____

Name of Medication:_____

Dosage:_____

Administration Method:_____

Directions/Time Schedule:_____

Special Instructions:_____

(Include additional pages as needed)

I affirm that the Student for whom this medication is prescribed is under my care.

_____	_____
PRINT Name of Physician	SIGNATURE of Physician
_____	_____
Physician's Street Address	Telephone
_____	_____
City/State/Zip Code	Date

AUTHORIZATION TO TREAT: In the event of an injury to Student or Student illness, School will make reasonable efforts under the circumstances to contact Parents. However, Parents understand that contacting Parents or attempting to contact Parents is not a prerequisite for School to make such arrangements and provide authorizations as necessary for Student to receive medical, dental, and/or hospital treatment and care. In case of injury to Student or Student illness, Parents authorize School, to take Student to the hospital, urgent care center, or other health care provider, and Parents consent to any x-ray examination, anesthetic, surgical or other medical treatment rendered by a physician, nurse, or other health care practitioner or emergency services provider. Parents understand and acknowledge that this authorization is given in advance of any specific injury or illness.

MEDICAL COSTS: Parents agree to assume any and all financial responsibility for the medical, dental, and/or hospital treatment and care administered to Student pursuant to Section 3 of this Agreement.

MEDICAL INSURANCE: Parents understand and acknowledge that School does not carry or maintain health, medical, or disability insurance coverage for Student and therefore Parents agree to assume the responsibility for such insurance coverage on Student for medical, dental, and hospital treatment and care administered to Student.

DUTY TO UPDATE MEDICAL INFORMATION: Parents affirm that the information contained in this Agreement is complete, true, and correct. If any information contained in this Agreement changes, Parents agree to immediately provide to School, by telephone and in writing, current information including, but not limited to, medical information, medications, allergies, or medical/physical conditions that may cause Student to need immediate medical attention during the school day or while Student is participating in School sponsored field trips, activities, athletics, and events held before, during, and after the school day.

USE OF HEALTH RECORD: Parents hereby consent to this information becoming part of Student's educational record and give permission to School to share Student's medical information with authorized School personnel, health care providers, or others who have a legitimate educational and/or safety interests in this information.

ACKNOWLEDGEMENT OF RISK: Parents understand and acknowledge that certain risks are inherent in taking both over-the-counter and prescription medication(s), in self-administering medication(s), and in receiving medical, dental, and hospital care and treatment, including, but not limited to, the risks associated with transportation to a hospital, urgent care center, or other health care facility to receive medical, dental, and hospital care and treatment; mild or severe adverse physical reaction to the over-the-counter or prescription medication (including emotional/psychological harm); misdiagnosis, delayed diagnosis, and failure to treat; paralysis and brain damage; temporary and permanent injury, temporary and permanent adverse reactions, and temporary and permanent disability; and death.

ASSUMPTION OF RISK: Parents assume responsibility for all risks arising out of or relating to authorized School personnel providing to Student over-the-counter and prescription medication, Student self-administering prescription medication, and authorized School personnel obtaining medical, dental, and hospital treatment and care for Student, whether described in Section 8 of this Agreement, known or unknown and inherent or otherwise. Parents agree that Student will also assume these risks and any other

risks arising out of, or relating to, authorized School personnel providing over-the-counter and prescription medication to Student or Student self-administering medication, whether described in Section 8 of this Agreement, known or unknown and inherent or otherwise.

RELEASE OF LIABILITY AND COVENANT NOT TO SUE: To the fullest extent permitted by law, Parents on their own behalf and on behalf of Student voluntarily release, discharge, waive, and relinquish any and all claims against School, its officers, trustees, directors, employees, volunteers, insurers, agents, and representatives (collectively "Released Parties" and individually "Released Party") relating to the administration of over-the-counter and prescription medications to Student, Student's self-administration of medication, and the administration of emergency medical, dental, and hospital treatment and care to Student, except to the extent caused by the gross negligence or intentional misconduct of the Released Party.

SEVERABILITY: If any provision of this Agreement is held invalid or unenforceable, the remainder of this Agreement shall nevertheless remain in full force and effect. If any provision is held invalid or unenforceable with respect to particular circumstances, it shall nevertheless remain in full force and effect in all other circumstances.

PARENTS HAVE CAREFULLY REVIEWED THIS *MEDICAL AND EMERGENCY INFORMATION, MEDICATION AUTHORIZATION, RELEASE, AND WAIVER AGREEMENT*, AFFIRM THE INFORMATION CONTAINED HEREIN IS COMPLETE, TRUE, AND CORRECT, AND FULLY UNDERSTAND ITS CONTENTS (INCLUDING THAT THIS AGREEMENT CONTAINS CERTAIN RELEASES OF LIABILITY), AND AGREE THERETO.

Unless one parent has had his/her parental rights terminated by court order, one living parent/guardian must sign this Agreement. For any questions or concerns regarding this requirement, please contact Dr. Brandi Odom Lucas, Principal at bodom@verbumdei.us.

PARENT/GUARDIAN 1:

PRINTED NAME: _____

SIGNATURE: _____ **DATE:** _____