



Health and Emergency Information

****Complete BOTH SIDES****

Student Information:

Name: _____ Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Grade _____ School: _____

Health Alert:

Allergies: _____

Restriction (food, illness, or injury): _____

Medicine to be taken at school: _____

Medical History: _____

Parent/Guardian Information:

1.) Name: _____ Relationship to Student: _____

Home#: _____ Cell#: _____ Work#: _____

Email address : _____

2.) Name: _____ Relationship to Student: _____

Home#: _____ Cell#: _____ Work#: _____

Email address : _____

3.) Name: _____ Relationship to Student: _____

Home#: _____ Cell#: _____ Work#: _____

Email address : _____

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Person to be called in an emergency other than Parent/Guardian:

4.) Name: _____ Relationship to Student: _____
5.) Home#: _____ Cell#: _____ Work#: _____
6.) Name: _____ Relationship to Student: _____
Home#: _____ Cell#: _____ Work#: _____

Family Physician: _____ Phone: _____
Family Dentist: _____ Phone: _____
Insurance Company: _____ ID#: _____

I give my consent and approval for my child's participation in Breakthrough at Norfolk Academy. I certify that my child is physically fit to take part in all activities. I authorize the Breakthrough staff to take such measures as deemed appropriate by them and make reasonable efforts to reach parents and emergency contacts.

Furthermore, in the event of serious illness or injury, examination, anesthetic, x-ray, medical or surgical diagnosis, treatment and/or hospital care may be rendered under the supervision and on the advice of a licensed physician when efforts to contact us are unsuccessful. I authorize any medical treatment which may be advised or recommended by an attending physician while my child is participating in Breakthrough. I will not hold Norfolk Academy responsible in case of accident or injury as a result of participation. Breakthrough agrees to notify the parent/guardian whenever the child becomes ill, and we will arrange to have the child picked up as soon as possible.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Administering Medication Policy

****COMPLETE BOTH SIDES****



*****Complete this form ONLY if your child requires medication during the day at BT.*****

It is preferable for students to receive medications at home under parental supervision. However, in some instances it may be necessary to take medications during school hours. In these cases, Breakthrough will cooperate with the parents and the physician according to the following guidelines:

1. **A physician's order is required for over-the-counter and prescription medications. Please submit the physician's order and the life-threatening allergy management plan and/or asthma action plan for emergency medications, such as EpiPens and inhalers.**
2. The medication must be for a reason the physician deems necessary for the health of the student.
3. A medication order form signed by a parent and physician must be submitted to Breakthrough with this form.
4. Requests for alterations in the dosage must be accompanied by an authorization from a parent and the physician.
5. A new order must be submitted each school year.
6. Medication must be in the original labeled container and obtained and delivered by parents. Upon request, pharmacists will provide one container for home and one for school.
7. The medication will be kept in a locked area at school except when teacher-administered on field trips.

Student Name: _____

Medication: _____

Condition prescribed for: _____

Side effects: _____

Treatment for side effects: _____

Date of order: _____ Duration of order: _____

Physician Name: _____

Physician Phone Number: _____

I grant permission for my child, _____, to receive the above medication as ordered by the physician according to Breakthrough's Administering Medication Policy.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

COMPLETE BOTH SIDES