



# Student Information and Medical Form (Annual)

## STUDENT INFORMATION

School Year: \_\_\_\_\_ to \_\_\_\_\_

Grade: \_\_\_\_\_

Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First Middle

## PARENT/GUARDIAN INFORMATION

Father or Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_  
 Active Email: \_\_\_\_\_

Mother or Guardian Name: \_\_\_\_\_

Address (if different from Father): \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_  
 Active Email: \_\_\_\_\_

(Indicate the best contact number in case of an emergency by placing a check(s) in the appropriate circles above)

Special Needs or Concerns: \_\_\_\_\_

## Medical Information

List any Food or Medication Allergies: \_\_\_\_\_

List any Medical Issues or Disabilities: \_\_\_\_\_

Is your child allergic to bee stings? Yes \_\_\_ No \_\_\_

Is your child on any continuous medications? Yes \_\_\_ No \_\_\_

If yes, please list: \_\_\_\_\_

## Emergency Information

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Contacts (if neither parents can be reached)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Permission to Acquire/Administer Medical Attention

I understand that NO MEDICINE of any kind will be given from the office without a completed Medication Authorization Form (print following pages if needed). This form must be returned, and an appointment must be scheduled with the school nurse.

I authorize Tabernacle Christian School to obtain proper medical attention for my child in case of emergency.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*ONLY PRINT THE FOLLOWING PAGES IF NEEDED\*\***



Dear Parent and Physician:

The Tabernacle Christian School's Medication Policy and Procedures were developed to protect the safety and welfare of our students. The policy intent is to encourage that students take required medications prior to, or after, school hours. For those few medications, which need to be administered during school hours, Board policy requires completion of this **Authorization for Medication** form each school year and every time there is a change in medication dosage or time and frequency of administration.

**Tabernacle Christian School defines medication to mean “any prescription or over-the-counter medication or supplement, which the medical care source deems essential to be administered during school hours.”** The **Authorization for Medication** form is required for both short-term and long-term prescriptions and over-the-counter medications. It needs to be signed by the physician and the parent specifying the dosage, time and frequency of medication. If the need for over-the-counter medication is short-term (less than a week), only a parent's note is required that states the medication, dosage and time and frequency of administration. The parent always has the option to come to school and administer the medication.

All medications, must be transported to school in the **original container** by the parent/guardian and administered by school personnel. For parents' convenience, it may be helpful to ask the pharmacist to label two containers, one for home and one for school. The only exception is that with prior documentation on the **Authorization for Medication** form students, who have permission to self-medicate, may carry rescue medications such as asthma inhalers, epi-pens or insulin.

Two important points to remember are:

- Parents are responsible for informing the school principal of any serious changes in the student's health or any change in the medication to be administered. Changes in medication, including altered dosage and changes in time and frequency of administration, require authorization from the prescribing physician on an **Authorization for Medication** form.
- It is a privilege for students to be allowed to self-medicate during school hours. Abuse of this privilege shall result in its revocation.

Thank you for your assistance in providing the necessary documentation and care for our students. We share your concern for their health and safety as well as their academic success.

**TABERNACLE CHRISTIAN SCHOOL  
AUTHORIZATION FOR MEDICATION**

**TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER**

Date: \_\_\_\_\_

Name of Student \_\_\_\_\_

DOB: \_\_\_\_\_ School: \_\_\_\_\_

**It is necessary that medication be given during school hours in order to keep this student in optimum health and to help maintain school performance.**

Medication \_\_\_\_\_ Dosage/mg \_\_\_\_\_ Route \_\_\_\_\_

Time(s) medication is to be given at SCHOOL \_\_\_\_\_

**\*Providers please note that "lunch time" can vary from 10:30 am to 12:30 pm**

**\*If medication is ordered as needed, please indicate specific circumstances when medication should be given (School staff, not licensed medical or nursing personnel, will be administering medication):**

\_\_\_\_\_

For K-12 students authorized to carry and administer rescue medications such as asthma inhalers, epi-pens or insulin or high school students authorized to carry and administer medication, with the exception of Class 2 controlled substances such as Ritalin, Oxycontin, Percocet, Adderol, Concerta, please check the appropriate box.

May self-medicate (student has demonstrated proficient use of medication).

May not self-medicate.

\_\_\_\_\_  
Medical Provider's Signature

\_\_\_\_\_  
Telephone Number

\*\*\*\*\*

**TO BE COMPLETED BY PARENT**

I hereby give permission for my child, \_\_\_\_\_ to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Tabernacle Christian School and their agents and employees from any and all liability that may result from my child taking the medication.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\*\*\*\*\*

**TO BE COMPLETED BY STUDENT AUTHORIZED TO SELF-MEDICATE**

I understand that it is a privilege for students to be allowed to self-medicate during school hours. Abuse of this privilege shall result in its revocation.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date