School Year:_______

STUDENT ALLERGY AND MEDICAL FORM

Please fill out this form completely and accurately and return it to school by August 10, 2017.

Student's Name:________________________________DOB:__/__/__ Grade:____________

Parent/Guardian(s) Name(s):____

Phone # Cell: ___________________________ Work:_______________________________

Allergist/Doctor:_______________________________Phone #:______________________

Or call Emergency Contact if unable to reach Parent/Guardian:

Name:______________________________ Phone:______________Relation:_____________

Allergies

Is your child allergic to any medication, food, etc? What is the severity of their allergy? What should be done in case of a reaction? (EpiPen, inhaler, etc.)

____

____

____

Medical Conditions

Does your child suffer from any pre-existing medical conditions (seizures, diabetes, mental health issues, etc.) What are the warning signs that we should be aware of, and what should be done in case of emergency?

____

____

List the Medication(s) your student takes for allergic reactions.

Name of Medication:	Dosage:	Time of Day:
_________________	_______________	__________________
_________________	_______________	__________________

Please flip over to back and fill out completely!

MEDICATION AUTHORIZATION FORM

(Please complete one form for each of your child's medications.)

Student's Name:______________________________ DOB:__/__/__

Allergies: ____

Medication: ____________________________ Dosage:__________

Reason for Medication or diagnosis: ___________________________

School:_______________________________ School Year:__________

In order for school personnel to administer any type of medication to the student, the Parent/Guardian must provide this signed authorization form. Medicine will be dispensed to the student by the school administration. The medicine must be sent to the school with complete instructions and in the original container with the Physician's Order OR pharmacy label firmly attached to the medication.

Please be sure to complete ALL of the information on this authorization form before returning it to school.

ANY OVER THE COUNTER MEDICATIONS MUST BE ACCOMPANIED BY A PHYSICIAN'S ORDER

The first dose of any new medication should NOT be given at school.

****

PARENT/GUARDIAN STATEMENT

□ I, the undersigned Parent/Guardian of the student named above, request that the school administration administer the above medication(s) to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the administration immediately of any changes. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or the medication will be destroyed.

***Parent is responsible to have medication available at school.**

Parent Signature:____________________________________ Date:__/__/__