MEDICAL FORM

HOLY FAMILY SCHOOL

(PLEASE PRINT CLEARLY AND FILL IN ALL INFORMATION)

STUDENT NAME: _____ GRADE:_____

MEDICAL HISTORY

Physician:_____Telephone _____

Dentist:_____Telephone _____

List any known severe illness:_____

Food Allergy _____

Drug Sensitivity_____

Please circle any medical condition:

ASTHMA	**GASTROINTESTINAL**	**SEIZURE DISORDERS**
CARDIOVASULAR	**MIGRAINES**	**OTHER:_____**
DIABETES	**ORTHOPEDIC _____**	

May your child's medical history be included on the confidential list? _____Yes _____No

MEDICATION

List the name and reason for medication your child is currently receiving. For additional medications, please attach a separate listing.

Name of Medication:_____Dose_____Time:_____

Reason:_____

Name of Medication:_____Dose_____Time:_____

Reason:_____

Parent/Guardians are responsible for providing to the school nurse all prescription medications needed for his/her child. All medications must be provided in the original container or package, labeled with the student's name and accompanied by the physician's order.

My child may be given the following (please check and initial medication you authorize:

_____Tylenol _____(initial) **_____Benadryl_____(initial)**

_____Antacid _____(initial) **_____Advil _____ (initial)**

As the parent or guardian, I release Holy Family School and the Phoenixville School District, its officers, agents, and employees from all claims or liabilities of any kind arising out of the dispensing of medication to the student pursuant to the authorization granted herein.

MEDICAL AUTHORIZATION AND CONSENT

In the event of an emergency which would require medical care and treatment to be administered to the student. I/we hereby authorize any physician, hospital or other health care provider to give emergency medical care and treatment to this student. The undersigned have read this Medical Authorization Consent Form and declare and affirm that I/we consent to the consents herein stated.

_____

Parent/Guardian (Please print) **Parental Signature** **Date**

_____

Parent/Guardian (Please print) **Parental Signature** **Date**

Name of Insurance Carrier:_____

POTASSIUM IODIDE CONSENT FORM (Please circle one.)

YES I **DO** give my consent for my child to be given potassium iodide (KI), when instructed by public Health officials, in the event of a radioactive emergency during school hours.

NO I **DO NOT** give my consent for my child to be given potassium iodide (KI), when instructed by public health officials, in the event of a radioactive emergency during school hours.

PARENTAL SIGNATURE:_____Date:_____