



# Blessed Teresa of Calcutta Education Center

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## MEDICAL HISTORY

Student Name \_\_\_\_\_ Grade \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone \_\_\_\_\_  
List any known severe illness: \_\_\_\_\_  
Food Allergy \_\_\_\_\_  
Drug Sensitivity \_\_\_\_\_

Please circle any medical conditions:

ASTHMA                                      GASTROINTESTINAL                                      SEIZURE DISORDERS  
CARDIOVASULAR                                      MIGRAINE                                      DIABETES  
ORTHOPEDIC                                      OTHER: \_\_\_\_\_

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 Blessed Teresa of Calcutta Education Center and the Spring Ford 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

Insurance: Please supply us with information regarding medical insurance coverage:

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## POTASSIUM IODIDE CONSENT FORM

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: \_\_\_\_\_