Southampton Academy Student Medical Information

Parents: Please provide medical information to help the Academy's nurse(s) and other staff members provide appropriate care in the event that the student becomes ill or injured while at school. A separate Medical information form is required for each student.

1. **Student Data**

   Student's Full Name: _____

   Sex: M F **Grade:** _____ Birth Date: _____

2. **Emergency Contacts**:
   List two people in addition to the parents to be contacted if the parents cannot be reached. Please **circle** to indicate whether the number is a work, at home, or a cell phone number.

   Father's Name: _____

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

   Mother's Name: _____

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

   "Back-up" Contact: _____ Relationship to Student: _____

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

   "Back-up" Contact: _____ Relationship to Student: _____

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

3. **Medical Information**:
   Please update as changes occur. Provide relevant information whether or not specifically requested.

   - **Allergies**: Bee Stings _____ Seasonal _____ Foods (Please list): _____

     Medications for Allergies: _____

   - **Chronic Illness or Conditions:** Asthma _____ Diabetes _____ Seizures _____

     Other (explain): _____

   - **Medications Taken Regularly (dosage, frequency):** _____

     _____

   - **Restrictions on Activities (such as P.E., sports):** _____

   - **Medical History—Significant Illnesses, Injuries, Operations**: _____

     _____

   - **Psychological or Emotional Issues—Significant Changes in Family/Home Environment, Other Matters for Staff Attention:** _____

4. Parent's Authorization for the Academy Staff to Provide or Obtain Emergency Medical Treatment:

As the parent or guardian of the above-named student, I authorize the Academy's nurses—as well as staff members acting under the nurses' guidance in compliance with school—approved procedures—to provide the student with first aid medical treatment or to obtain professional emergency medical assistance as needed. I authorize staff to share the student's medical information as appropriate in providing first aid or emergency medical care. I understand that costs for ambulance and emergency room services are my (the parent's) responsibility and are not covered by the Academy or by its insurance.

Parent's Signature: _____ Date: _____

5. First Aid & Medical Care—Requests, Restrictions (Kindergarten through 12th Grade Only)

Over-the-Counter Medicines—Please indicate (by checking below) over-the-counter medicines that the nurse or other Southampton Academy staff members under her supervision may administer to the student without contacting you for specific permission. ***(Excluding Pre-Kindergarten)***

- ***Oral Medications*** for headache, muscle aches, menstrual cramps, sore braces, seasonal allergies, etc.:

  Acetaminophen (Tylenol) _____ Ibuprofen (Advil) _____ Other (provided by the parent) _____

  Zyrtec/Claritin _____ Benadryl _____

- ***Oral Medications*** for mild sore throat, mouth, gum pain or coughing:

  Cough Drops (6th-12th Grade only) _____ Chloraseptic Spray/Equivalent _____ Orajel _____

  soft peppermint _____

- ***Oral Medications*** for sour stomach, acid indigestion, diarrhea:

  Chewable Antacid Tables (Tums/Equivalents) _____ Imodium/Equivalent _____

  Mylanta/Equivalent _____ Dramamine (nausea) _____

- ***Topical Medications*** for minor wounds:

  Neosporin/Equivalent _____ Vaseline/Equivalent _____ Peroxide (cleanser) _____

- ***Topical Medications*** for bug bites, hives:

  Hydrocortisone Cream _____ Calagel/Equivalent _____ Benadryl/Equivalent spray or lotion _____

- **Intranasal** Medications for runny, stuffy nose; dry, irritated nasal passages or nose bleed:

  Afrin/Equivalent _____ Saline (non-medicated) nasal spray _____

- **Intraocular Medications** for dry, itchy eyes:

  Visine/Equivalent _____ saline _____ Opcon-A (itchy eyes) _____

6. Parent Does Not Authorize Staff to Give the Student Non-Prescription (over-the-counter) Medicines:

Please initial here to indicate that the student **should not** be given acetaminophen (Tylenol) or ibuprofen (Advil) without specific permission from the parent. _____ By checking here, you request the nurse or another staff member to contact you whenever the student requests or seems to need a minor pain reliever.

7. Parent Authorizes Staff to Give the Student Non-Prescription (over-the-counter) Medicines: (Kindergarten through 12th Grade Only)

As the parent/guardian of the above-named student, I hereby authorize the Academy's nurses or other staff members under her guidance to provide my child with medications as indicated above in compliance with label instructions.

- **I confirm that the student has taken the medicines previously and has suffered no adverse reactions to them.**
- **I understand that the school staff's offering non-prescription medicines in the absence of obvious symptoms is a convenience and courtesy offered by the Academy and is not intended to be diagnostic.**
- **I understand that the school nurse will contact me (the student's parent) regarding proper disposal of unused medicines and/or empty prescription bottles, and that the nurse will dispose of unused medicines seven days after parent notification unless otherwise instructed.**

I hereby release Southampton Academy from any liability in connection with the administration of the requested and authorized medications.

Parent's Signature: _____ Date: _____

Parent's Name, Printed: _____ Date: _____

8. Medical Data

Child(ren)'s Doctor: _____ Phone: _____

Child(ren)'s Dentist: _____ Phone: _____