# Student Medical Information Form
# K-12

**Parents: A separate Student 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.

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

  **Medication given for Allergic Reaction**: _____
- **Chronic Illness or Conditions:** Asthma _____ Diabetes _____ Seizures _____

  Other (explain): _____
- **Medications/Herbal/Homeopathic Remedies Taken Regularly (dosage, frequency):** _____

  _____
- **Restrictions on Activities (such as P.E., sports):** _____
- **Medical History-Injuries, Surgeries, Psychological, Emotional or other special concerns**:

  _____

**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.

**Signature of Parent/Legal Guardian**_____ 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 PreKindergarten)***

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

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

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

  Ludens Throat Drops _____ Cough Drops _____ Benadryl Elixir _____ Orajel _____

- ***Oral Medications*** for sour stomach or acid indigestion:

  Chewable Antacid Tables (Tums or equivalents) _____

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

  Neosporin (or equivalent) _____ Vaseline (or equivalent) _____

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

  Hydrocortisone Cream _____ Calagel (or equivalent) _____ Benadryl (or equivalent) spray or lotion _____

**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.

**Signature of Parent/Legal Guardian**:_____ Date: _____

**Parent's Name, Printed:** _____ Date: _____

**8. Medical Data**

**Pediatrician/Primary Care Provider:** _____**Phone:** _____

**Specialist(s):** _____**Phone:** _____

**Dentist:** _____ **Phone:** _____

**Orthodontist (if applicable):** _____ **Phone:** _____

**Case Worker (if applicable):** _____ **Phone:** _____

**9. Notification of Sickness Authorization**

The school will notify the parent(s) when the child becomes ill and paret(s) will arrange to have the child picked up as soon as possible if requested by the school.

Parents will inform the school within 24 hours (or next business day( if the child or an immediate family member develops a reportable communicable disease.

**Signature of Parent/Legal Guardian**: _____ **Date:** _____