Curé of Ars Catholic School

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT 2016-2017

(To be completed by parent--One per family)

_____

Family Name

Student's first & last name:

1. _____/Grade: _____, 4. _____/Grade: _____

2._____/Grade: _____, 5. _____/Grade: _____

3.:_____/Grade:_____, 6. _____/Grade: _____

Students live with:__Both Parents __Mother __Father, Legal custody___Mom___Dad___Joint

Dad:_____ Address: _____Telephone( )_____
Place of Employment: _____ Cell Phone #: ( )_____
Work #( ) _____ E-Mail:_____

Mom: _____ Address:_____ Telephone:( )_____
Place of Employment: _____Cell Phone #: ( )_____
Work #: ( )_____ E-Mail:_____

Step-Dad:_____ Address:_____ Telephone:( )_____
Place of Employment: _____ Cell Phone #: ( )_____
Work #: ( )_____ E-Mail:_____

Step-Mom:_____ Address:_____ Telephone( )_____
Place of Employment: _____ Cell Phone #:( )_____
Work #( )_____ ___ E-Mail:_____

IN CASE OF AN EMERGENCY AND A PARENT CANNOT BE REACHED, THE FOLLOWING *LOCAL* PEOPLE CAN BE CONTACTED TO RESPOND IN THE PARENT'S ABSENCE.

Name	Phone	Relationship
1.	H: _____ W: _____ C:	
2.	H: _____ W: _____ C:	
3.	H: _____ W: _____ C:	

_____/_____
Name of Physician and Phone # Hospital Preference

_____/_____
Name of Dentist and Phone # Name of Orthodontist and Phone #

OVER PLEASE

CONSENT TO ADMINISTER MEDICATION

School personnel must have parental consent to dispense **over the counter** medications. I understand that any school employee who administers any drug to my child(ren) in accordance with written instructions from a physician, dentist, or parent shall **not** be liable for damages as a result of an adverse drug reaction suffered by my child(ren) because of administering such a drug. I hereby authorize the school nurse or persons designated to administer medication in her absence, to administer the following medications (OTC) and/or prescriptions. All medication will be maintained in the nurses' office and dispensed according to label instructions and at the discretion of the school nurse. All prescription medications **MUST** be brought in their original pharmacy container and appropriately labeled. If it is necessary for the student to retain possession of medications (i.e. inhalers), this must be discussed with the school nurse, requested in writing via this form and approved by your child's physician.

I hereby give permission for _____ to be administered the following:
Name of student(s)

Are my children allergic to any medications? ____Yes _____No
If so, please list them:
Name:_____
_
Name:_____

Non-Prescription:

_____ You may give my child(ren) "over the counter" medications.

_____I do not want my child taking any medications at school.

Prescription Medication (to be given at school):

Child's Name_____ Medication_____ Dose_____ Time/Day_____ Reason_____

Child's Name_____ Medication_____ Dose_____ Time/Day_____ Reason_____

Child's Name_____ Medication_____ Dose_____ Time/Day_____ Reason_____

Child's Name_____ Medication_____ Dose_____ Time/Day_____ Reason_____

Please list any known allergies that your children have or daily medications that your children take at home.

Child's Name_____

Child's Name_____

Child's Name_____

Child's Name_____

If your child(ren) should become seriously ill or injured at school and you or your physician cannot be reached within a reasonable length of time, may a staff member of Curé of Ars Catholic School have permission to take appropriate action to see that your child gets emergency hospital care via ambulance? ____ **YES** ____**NO**

I, the undersigned, do hereby authorize officials of Curé of Ars Catholic School to contact directly the persons named in this sheet, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the said child(ren).

In the event physicians, other persons named in this sheet, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in this judgement, for the health of the aforesaid child(ren).

I will not hold the Archdiocese of KC in Kansas financially responsible for the emergency care and or transportation for the said child(ren).

Statement of Consent:
In order to better serve the health needs of my child, I hereby give permission for the transfer of health history, immunization record to the Kansas Immunization Program and screening records to the teachers, staff and other health professionals that deal with my child(ren) at Curé of Ars Catholic School. I acknowledge this will keep all staff members informed of any changes in my child's health. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. In addition, all of the information provided on this form is accurate to the best of my knowledge.

_____

Signature of Parent or Guardian **Date**