Cathedral Academy

Student Health Information and Treatment Consent

2023-24 School Year

Student's (FULL) Name: ____**Grade**:__________________

Teacher: _______________________________ Birthday: _______ Sex: M/F Race: _________________________

Student's Dr: ____________________________________ Phone: ______________________________________

*Primary Parent/Guardian's Name: ____Relationship: ___________

Primary Phone: __________________________ Work Number: _______________________________________

*Secondary Parent/Guardian's Name: _______________________________________Relationship: ___________

Primary Phone: __________________________ Work Number: _______________________________________

Emergency Names and Numbers

These individuals are authorized to make medical decisions for my child and pick my child up if I am unavailable:

Name: ____________________________Relationship:_______________Phone:___________________________

Name: ____________________________Relationship:_______________Phone:___________________________

Name: ____________________________Relationship:_______________Phone:___________________________

Name: ____________________________Relationship:_______________Phone:___________________________

Medical History

Has your child ever had any of the following medical problems? Check ALL that apply. Write in any not listed.

Lung/Asthma ___ Heart ___ Diabetes ___ ADD/ADHD ___ Hearing ___ Mental/Behavioral ___

Vision ___ Nose Bleeds___ Epilepsy (seizures) ___ Migraines/chronic Headaches ___

Intestinal/Acid reflux ___ Seasonal Allergies/Sinus ___ Liver____ Kidney/bladder___ Bone/Back ___

Other____

Explain any checks above, and any additional medical history: ____

____

Please list any assistive devices that your child uses (glasses, hearing aids, leg braces, crutches, teeth braces, etc.)

____

Any limitations with physical activity: ____

Is your child allergic to any of the following: Check **ALL** that apply *(continues on next page):*

__FOOD:____ Reaction: ______________________________

__FOOD INTOLERANCES: ________________________________Reaction: ______________________________

__MEDICINE(S):____ Reaction: ______________________________

__INSECT BITES/STINGS: ___________________________________Reaction: ______________________________

__ OTHER: ____Reaction: ______________________________

Does your child have an Epi-Pen? **Y/N** Inhaler or nebulizer? **Y/N** Seizure Medicine? **Y/N**

Will your child be carrying an inhaler or Epi-Pen with them? (UPPER SCHOOL ONLY)**Y /N (Authorization form required)**

Is your child on Prescription Medication that he/she will need to take at school? **Y /N (Authorization form required)**

If yes, please list medication(s):____

Please list any home medication(s), if any: ____

Any other medical issues or concerns: ____

____I give permission for my child to receive medication(s) or medical treatment as deemed necessary by the school nurse or school designee in the nurse's absence. Prescription medications may be given at school with a **signed Parent/Physician Authorization form and a properly labeled container from the pharmacist.** (This medication must be brought in/taken home by an adult). In order to follow DHEC regulations, we can only accept medications that are in the original containers with original labels intact. (Most pharmacies will divide medications and provide additional containers upon request for this purpose. Over-the-counter (OTC) medication must be administered by the school nurse or school designee in the nurse's absence. STUDENTS MAY NOT CARRY MEDICATION ON THEIR PERSON EXCEPT WITH EXPRESSED PERMISSION FROM THEIR PHYSICIAN, PARENT, AND ADMINISTRATION. (EXAMPLE: EPI-PENS AND INHALERS)

____In case of an emergency and **I CANNOT BE REACHED,** my child will be transported to the nearest emergency room by EMS. I authorize the school nurse, or school designee, through its trustees, officers, directors, employees, agents, or representatives, to render or obtain such emergency medical care or treatment for my child as may be necessary should any illness, injury, harm or accident occur to my child.

I understand and acknowledge that Cathedral Academy, Inc. does not provide health or medical insurance, and I agree that I will be financially responsible for any bills incurred as a result of medical treatment, including emergency medical treatment and/or transportation to a medical facility, for my child. My signature also gives permission to release/obtain information to/from physicians or other state agencies if necessary.

___I give permission for my child to have a hearing exam at school.

___ I give permission for my child to have a vision exam at school.

Parent/Guardian Signature: ____ **Date**: ______________________

By signing this form, I acknowledge the responsibility of providing the school with accurate and updated information and will keep the school updated with any changes throughout year as it changes

Cathedral Academy

List of Over the Counter Medications and Administration Indications for Cathedral Academy

Medication	Indication
Acetaminophen	Fever above 100, pain-dosing per label
Ibuprofen	Fever above 100, pain-dosing per label
Antacid	Indigestion, heartburn, sour stomach-dosing per label
Benadryl	To be administered at the onset of systemic allergic reaction characterized by rash, swelling, mild/mod respiratory distress due to environmental/food/insect allergies. Use liquid/chewable for faster absorption. Further emergency care will be facilitated as warranted by condition. Dosing per label
Epinephrine	To be administered at the onset of severe allergic reaction characterized by severe swelling and respiratory distress. Dosing per label
Glucose gel	To be administered orally for hypoglycemic episodes, BEFORE unconsciousness occurs. Dosing per label
Cough drops	Temporary relief of cough, and sore throat. Dosing per label
Orajel	Temporary relief of toothaches and minor irritations of the mouth. Dosing per label
Benadryl/Hydrocortisone cream	Temporary itch relief for insect bites, eczema, psoriasis, minor skin irritations, rashes, poison ivy, poison oak, poison sumac. Dosing per label
Triple Antibiotic Ointment	Minor wounds prior to bandaging. Dosing per label
Zyrtec/Allegra	Relief of allergy related symptoms, mild allergic reaction, or indication noted on medication label
Calamine Lotion	To dry oozing and weeping of poison ivy, poison oak, poison sumac. Dosing per label
Saline Eye Drops	For cleansing the eye to help relieve irritation or burning by removing loose foreign material
Sting Relief (antiseptic pad)	To help prevent infection in minor scrapes and temporary relief of itching of insect bites. Dosing per label
Vaseline	Provides dry skin relief. Helps protect minor cuts, scrapes and burns

I authorize the above medications (or generic form or the medication) to be administered to my child____, per the above protocols. **I have drawn a line through any medication(s) that I do NOT wish to be given**. This consent will be renewed annually and may modified/withdrawn at any time.

Parent/Guardian Signature: ____ **Date**: ___________________