



Student's (FULL) Name: _____ Grade: _____

Teacher: _____ Birthday: _____ Sex: M/F Race: _____

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 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.

__FOOD: _____ Reaction: _____

__FOOD INTOLERANCES: _____ Reaction: _____

__MEDICINE(S): _____ Reaction: _____

__INSECT BITES/STINGS: _____ Reaction: _____

__OTHER: _____ Reaction: _____

*****Cathedral Academy cannot and does not guarantee an allergen-free environment*****

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 DPH 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 vision exam at school.

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

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



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

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 of 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: _____