



2026-27 Student Health Information and Treatment Consent

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

MEDICAL HISTORY

Has your child ever had any of the following medical problems? Check ALL that apply.

- | | | |
|---|--|--|
| ☐ ADD/ADHD | ☐ Food Intolerance | ☐ Nose Bleeds |
| ☐ Asthma | ☐ Hearing | ☐ Seizures |
| ☐ Blood Pressure | ☐ Heart | ☐ Stomach/Acid Reflux |
| ☐ Bone/Joint | ☐ Kidney/Bladder | ☐ Vision |
| ☐ Diabetes | ☐ Migraines/Chronic Headaches | ☐ Other |

Explain any checks above and any additional medical history: _____

Is your child allergic to any of the following: Check ALL that apply.

- | | |
|---|---|
| ☐ FOOD: _____ | ☐ INSECT BITES/STINGS: _____ |
| ☐ MEDICINE(S): _____ | ☐ OTHER: _____ |

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

MEDICATIONS

Does your child have an EpiPen? **Y / N** Inhaler or nebulizer? **Y / N** Seizure Medicine? **Y / N**

If your child currently has an epinephrine auto-injector for an allergy, is on daily medication for asthma, or is on medication for seizures, an action plan will need to be submitted. These forms will be kept on file so that we know how best to care for your child should an emergency occur.

Is your child on Prescription Medication that will need to be taken at school? **Y / N**

If yes, please list medication(s): _____

Prescription medications may be given at school with a signed Authorization for Prescription Medication at School form and a properly labeled container from the pharmacist. 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.

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

CONTINUED ON THE REVERSE PAGE

Please review the options below. Initial each item to indicate your agreement, and provide your signature at the bottom of this page.

____ I give permission for my child to receive medical treatment as deemed necessary by the school nurse or school designee in the nurse's absence.

____ 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 gives permission to release/obtain information to/from physicians or other state agencies if necessary.

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 the school year as it changes.

Parent/Guardian Name (please print): _____

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

Over-the-Counter Medication Administration Authorization Form

If you want your student to be able to receive OTC medications, read & sign below.

Acetaminophen	Fever above 100, pain. Dosing per label.
Antacid	Indigestion, heartburn, sour stomach. Dosing per label.
Artificial Tears Eye Drops	Used to lubricate dry eyes and help maintain moisture on the outer surface of the eyes. May also be used to flush foreign objects from eyes. Dosing per label.
Benadryl	To be administered at the onset of systemic allergic reaction characterized by mild symptoms due to environmental/food/insect allergies. Use liquid/chewable for faster absorption. Dosing per label.
Benadryl/Hydrocortisone cream	Temporary itch relief for insect bites, eczema, psoriasis, minor skin irritations, or rashes. Dosing per label.
Calamine Lotion	Used to dry oozing and weeping of poison ivy, poison oak, and poison sumac. Dosing per label.
Cough drops	Temporary relief of cough and sore throat. Dosing per label.
Epinephrine	To be administered at the onset of systemic allergic reaction characterized by severe symptoms due to environmental/food/insect allergies. Dosing per label.
Glucose gel	To be administered orally for hypoglycemic episodes, BEFORE unconsciousness occurs. Dosing per label.
Ibuprofen	Fever above 100, pain. Dosing per label.
Orajel	Temporary relief of toothaches and minor irritations of the mouth. Dosing per label.
Sting Relief (antiseptic pad)	To help provide temporary relief from itching of insect bites. Dosing per label.
Triple Antibiotic Ointment	For treating and preventing infection due to minor cuts, scrapes, and burns prior to bandaging. Dosing per label.
Vaseline	Provides dry skin relief, including dry lips.
Zyrtec	Relief of allergy-related symptoms, mild allergic reaction, or indication noted on medication label. Dosing per label.

- Students may not carry medication on their person.
- Over-the-counter (OTC) medication must be administered by the school nurse.
- 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 be modified/withdrawn at any time.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____