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| **EMERGENCY INFORMATION** |
| **Student’s Name:** | **DOB (mm/dd/yyyy):** | **Grade:** |
| **Street Address:** | **City:** | **State / Zip:** |
| **Parent/Guardian Name:** | **Home Phone / Cell Phone:** | **Work Phone:** |
| **Parent/Guardian Name:** | **Home Phone / Cell Phone:** | **Work Phone:** |
| **Parent/Guardian Name:** | **Home Phone / Cell Phone:** | **Work Phone:** |
| **Emergency Contact Name (someone other than above):** | **Phone:** | **Relationship to Student:** |
| **Emergency Contact Name:** | **Phone:** | **Relationship to Student:** |
| **Student’s Physician:** | **Address:** | **Phone:** |
| **Student’s Dentist’s** | **Address:** | **Phone:** |

I give permission for North Tampa Christian Academy to give my child the following over-the-counter medication(s) when needed. This permission is given until rescinded:

[ ]  Ibuprofen (dose\_\_\_\_\_\_\_\_\_) [ ]  Tylenol (dose \_\_\_\_\_\_\_\_\_\_) [ ]  Aleve (Naproxen Sodium)

[ ]  Antacid [ ]  Cough Drop [ ]  Benadryl Topical [ ]  Benadryl Oral (\_\_ 12.5mg \_\_ 25 mg)

[ ]  Topical Burn Relief [ ]  Hydrocortisone Cream [ ]  Triple Antibiotic Ointment

[ ]  Biofreeze [ ]  Bug Spray [ ]  Pepto-Bismol [ ]  Calamine Lotion

*\*If no dosage provided, appropriate age/weight dosage will be given when permission is granted above.*

**Prescription Medication:**

*If your child has any medication that needs to be administered during school hours, please provide the medication in the original packaging with the prescription label and a note or prescription from the provider. Medication will be kept locked in the school Health Office unless otherwise arranged. Per provisions of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from administration of the medication(s). I also grant permission for school personnel to contact the physician, APRN, or PA if there are questions or concerns about the medication(s).*

My child has the following medication(s) that need(s) to be administered during school hours:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medication** | **Amt/ Strgth** | **Dose** | **Med Exp Date** | **Time** | **Purpose of Medication** | **Date Begins** | **Date Ends** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

*Is there an illness, ailment, or condition we should be made aware of ( i.e., asthma, diabetes, etc.?):*

*Yes* [ ]  *No* [ ]  *If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Please list any (include regular) medications your child takes at home (include dosage and times):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*I, the undersigned parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby consent to all above statements and any service NTCA personnel may offer in conjunction with items I have approved with this form. I also understand that only designated staff, such as the school health office personnel or administration, will have access to the completed form. The form will be stored in a secure location on campus and securely carried on approved trips away from the school campus.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature Date*