

Kingsport City Schools Medical Form

2011-2012

This form is required for ALL After School and School Related Activities

A Parent/Guardian must complete ALL Items on this form.

*****Additional forms will need to be completed if student takes Medication for Asthma or Allergies.**

If questions, call the appropriate school nurse.

Name of Extra-Curricular School Activity: _____

Student's Name: _____
(Last) (First) (Middle)

Student's Address: _____
(No.) (Street) (City) (State) (Zip)

Student's Date of Birth: _____ Grade: _____

Father's Name: _____ E-Mail: _____

Father's Address: _____

Father's Home Phone #: _____ Work Phone #: _____ Cell #: _____

Mother's Name: _____ E-Mail: _____

Mother's Address: _____

Mother's Home Phone #: _____ Work Phone #: _____ Cell #: _____

Student's Physician: _____ Phone #: _____

Health Insurance Company: _____

Insurance Company Address: _____

Group #: _____ ID / Subscriber #: _____

Social Security number of Card Holder: _____ - _____ - _____

Type of Insurance: Private _____ Group _____

No Medical Insurance at this time _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY AND YOU CANNOT BE REACHED
(Other Than Those Listed Above)

Name: _____ Home Address: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

HEALTH HISTORY

Student's Name: _____

Date of Birth: _____

Drug Allergy (List) _____ **Food Allergy (List)** _____

Insect Bite Allergy (Life Threatening) _____ **Latex Allergy** _____ **Seasonal Allergy** _____

Epi-Pen required for Allergy? _____ **Other Medications used for Allergy** _____

Asthma _____ **Inhaler required?** _____ **Frequency used?** _____ **Nebulizer required?** _____

Other Medical Problem(s) _____

Current Medications: _____

_____ **Last Tetanus Shot:** _____

Details of Treatment / Activities to be Restricted (Requires Physician Note): _____

Medications/ Parental Permissions

Permission for Over-the-Counter Medications

I represent that I am the mother, father, guardian of the above child. I give my permission for KCS personnel to administer, or assist in the self administration of the parent-provided medications that I have *initialed*.

(Parent / Guardian Signature)

MEDICATION

Tylenol	Mylanta	Vaseline
Ibuprofen	Artificial Tears or Baush	Baby Oil
Bendadryl (Severe Allergies Only)	Baush & Lomb Eye Wash	Dry Skin Lotion
Sudafed*	Dramamine*	Immodium AD*

***THESE MEDICATIONS ARE FOR OVERNIGHT SCHOOL TRIPS ONLY!**

Permission for Prescription and All Other Over-the-Counter Medications

Before administering any prescribed or over-the-counter medication not on the above approved list the School Clinic must have on file:

- Completed Physician Form for Administration of Medication for **each medication (over-the-counter & prescribed medication)**. This form must be **completed** by your **Physician**.
- Each medication must be in the original, unopened container with the original label listing the ingredients.
- The student's name must be written on the container.
- Students are not allowed to share medications, including sunscreen and chapstick.

(The Physician Form for Administration of Medication can be obtained from the School Clinic and is good for one school year only).

Permission for Emergency Medical Treatment

In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic.

Permission for Accompanying Physician: I give permission for any physician who is present at any after school and/or school related activities to provide first aid/medical treatment to my child if necessary.

(Parent / Guardian Signature)