

The Columbus Academy Emergency Medical Authorization/Travel Authorization/Release and Health History Form 2010-11

Student personal information

Name Grade Birth Date
Phone Gender F M

Consent Information

As the parent/guardian of the above named student, I hereby acknowledge my understanding that off campus travel, including in some cases, overnight stays, is an important part of the educational and athletic programs of the school, and that such travel for educational or athletic programs or events may be by one or more contract buses, school vans or by private vehicle driven by a school employee. The school shall notify me before any such off campus travel is undertaken and shall provide me with details of such travel, including the purpose of such travel, a schedule of events including times of departure, arrival and return, and mode of travel. I hereby authorize my child to participate in such trips during the current school year, and I release and forever discharge The Columbus Academy and its trustees, employees, agents, their heirs, successors and assigns, either jointly or severally, from any and all claims, damages, obligations, causes of actions or suits, resulting from bodily injury to my child or damage to or loss of my child's property arising from participation in such travel, programs and events.

Parent / Guardian or Other Emergency Contact Information (please provide 4 contacts)

Name Email
Home Phone Cell Phone Work Phone
Address Relationship
City State Zip

Name Email
Home Phone Cell Phone Work Phone
Address Relationship
City State Zip

Name Email
Home Phone Cell Phone Work Phone
Address Relationship
City State Zip

Name Email
Home Phone Cell Phone Work Phone
Address Relationship
City State Zip

Insurance Information

Insurance Co. _____ Phone _____

Policy Holder _____ Policy/Group No. _____

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

To Grant Consent: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the following health care providers, or if the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Physician _____ Phone _____

Medical Specialist _____ Phone _____

Dentist _____ Phone _____

Local Hospital _____ Phone _____

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Grant consent to travel off campus? (required) Yes No

Grant consent for emergency care? (required) Yes No

Specific instructions or facts concerning the child's medical history, including allergies, medications being taken and any physical impairments or chronic conditions to which a physician should be alerted include:

School nurse may contact above healthcare practitioners regarding student's health if necessary. Yes No

Parent's Authorization for Dispensing Over-The-Counter Medications

The Columbus Academy has the following medications available for dispensing to students by the school nurse and athletic trainer (for grades 7-12) as needed. In order for the student to receive these, a parent must provide written consent.

I give permission for my child to receive the medications checked below as administered by the **school nurse** or her designate and by the **athletic trainer** (for grades 7-12).

- | | |
|---|---|
| <input type="checkbox"/> 1%Hydrocortisone cream | <input type="checkbox"/> Loratadine (Claritin) - anithistamine |
| <input type="checkbox"/> Acetaminophen (Tylenol) - liquid, chewable, and tablet | <input type="checkbox"/> Maalox - antacid |
| <input type="checkbox"/> Benadryl - liquid and tablet | <input type="checkbox"/> Mucinex - decongestant |
| <input type="checkbox"/> Benadryl - topical | <input type="checkbox"/> Neosporin - triple antibiotic ointment |
| <input type="checkbox"/> Caladryl lotion - topical analgesic | <input type="checkbox"/> Sudafed - decongestantage (age 6 and over) |
| <input type="checkbox"/> Cough drops | <input type="checkbox"/> Tums tablets - antacid |
| <input type="checkbox"/> Ibuprofen (Advil, Motrin) - liquid, chewable, and tablet | |

Additional information or directions for the use of the above medications

Please list all over the counter and prescription medications that your child takes and the reason for taking them.

Which medications will need to be given at school? ([Click here for required forms](#))

Does your child use an inhaler? ([Click here for required forms](#))

Yes No

Does your child use an epi-pen? ([Click here for required forms](#))

Yes No

Where will the inhaler and/or epi-pen be stored?

- athletic trainer's office bookbag classroom dining hall nurses's office

Other locations epi-pen will be stored.

Additional concerns for the school to know about your child.

Immunization Record

For 7th grade:

DPT					
Polio					
MMR					
Hib					
HEP B					
Varicella					

Tdap _____ or Td _____

Other Immunizations

Has your child had chicken pox? Yes No If so when? _____

Health Conditions

Please check any that this child has

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Spinal Curvature | <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Allergies, Food | <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Allergies, Insect Sting | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Allergies, Seasonal | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating disorder,obesity | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excema | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Vision loss |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Wetting during day |

[Click here for asthma, allergy, diabetes or seizure forms.](#)

Please explain any of the above or other health conditions or injuries.

Please give any specific directives for care of student at school.

Physical Exam

Height _____ Weight _____ Blood pressure _____

Is there any reason this student cannot participate in a full program of school activities?

Yes No

If yes, explain

Perinatal History

Did the mother have any complications during pregnancy or birth?

Yes No

If yes, explain

Was the infant born:

full term early late

Birth weight _____

Did the infant have any problems while in the nursery?

Yes No

If yes, explain

Public School District/Daily Transportation Information

Public School District (required)

Public school **building** your child would attend this year based on your residence. (required)

Other than Parents/Guardians, list the names of those picking up your child daily:

Normal transportation home from school. Bus Carpool CASE Daycare Van Student Vehicle

Bus Route (if applicable)

Student Vehicle Information (if applicable)

Make	Model	Color	Year
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The undersigned agrees to the accuracy of, and to be bound by and to comply with, the provisions set forth in this document as if the undersigned has manually signed.

Digital Signature (required)

Your Digital Signature can be found with the instructions you received in the mail.

Date

Username