

10224 Baileywick Rd Raleigh, NC 27613 919.786.0114

2018-2019 Medical Consent Form

Innovative Classical Learning Grade (2018-2019):_____ Date of Birth Student's Name Home Phone Address City Zip Code Mother's Name Cell Phone **Email** Father's Name Cell Phone **Email** *Please put an asterisk by the preferred form of contact (i.e. home phone, cell phone, or email) List two contacts who will assume responsibility for your child in the event you cannot be contacted. Name / Relationship Home Phone Cell Phone Home Phone Name / Relationship Cell Phone **MEDIC ALERT:** Please provide information critical to a first responder (e.g. Diabetic, severe allergies, etc.) If necessary, your child will be provided basic first aid and medication administered according to school policy (see handbook for medication guidelines). Injury assessment and intervention may include the use of topical skin antibiotic and anti-itch medication as appropriate. Pain relief medication will be administered based upon your child's level of discomfort and nature of the discomfort. Dosage will be determined by your child's weight and/or age. Consent for Medication - circle YES or NO Acetaminophen (Tylenol): YES NO Cough/sore throat lozenge: YES NO Antihistamine (Allergic Reaction): YES NO Hydrocortisone Cream: YES NO Bacitracin ointment: YES NO Tums: YES NO Children's Pepto Chews: YES NO Do you carry medical/hospital insurance? Hospital of Choice Name of Insurance Company Policy # Group # Child's Doctor Address Telephone

Address

Telephone

Child's Dentist



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Student's Name	Date of Birth	Grade (2018-2019)
ALLERGIES (Food or medications):		
Medications (Daily or as needed*):		
*You must notify the school nurse of any changes in medications of	or dosages throughout the s	school year.
Will your child take daily medications at school? required Medication Administration Form.	If YES you must email the	school's registered nurse for
Health Concerns (Dietary or Medical):		
Authorization and Consent to Understanding that my child may need emergency treatment durin attends Trinity Academy, I hereby authorize the School, through the administer such first aid or other minor medical treatment as shall for my child to receive such treatment. I understand that the School requiring immediate medical care for my child and if the School is duly qualified physician at the nearest hospital or emergency cente be shared with emergency medical personnel. This authorization as I acknowledge that it is my responsibility to keep my child's records as they occur, e.g. Telephone numbers, work location, emergency c immunization records. I agree to notify the school clinic if my child. I understand that before medication is dispensed to my child, I will information required to accurately administer the medication. Medicine MUST be in the original container with my child's name a by the parent or legal guardian.	ag school hours or at school he school nurse (RN) or other be deemed best under the sol will attempt to notify me is unable to notify me, it will be a school-sponsor as current to reflect any sign contacts, child's physician and is exposed to any communication provide written authorizated.	er qualified personnel, to circumstances, and I consent in the event of an emergency have my child treated by a provided to the School may ed programs. ificant changes, in writing, and health status, and icable disease. ion, which includes specific
Parent signature	Date	

IMPORTANT NOTE:

STUDENTS WILL NOT BE ALLOWED TO ATTEND CLASS UNTIL THIS FORM IS COMPLETED, SIGNED AND RETURNED TO THE SCHOOL OFFICE. ADDITIONALLY, IMMUNIZATION FORM 3231 MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.

Student Emergency Medical Plan

Please complete the below questions <u>only</u> if your student has a specific medical need that needs monitoring or medical supplies kept on campus. Those who complete this plan may be contacted by Trinity Academy staff for additional information or plans.

Outline the medical condition that requires an emergency medical plan. Be specific – if it is related to allergies, what causes it? How frequent has this event happened? Recommended plan of action (may be attached if from physician): Please list any medicines regularly taken even if not related to this plan: Please list any allergies or other medical information that may be useful in the event this sheet is used: Please list below any medical materials that need to be maintained as part of this plan (items such as an epi pen) and provide two (2) of each material to be maintained at the school (one kept in the classroom and one in a central location).

Please note that some medical events will require a call to 911 regardless of parent requests. Likewise, when in doubt, staff will always choose the safest option even if that means calling 911. ***If your student has a medical need that requires emergency supplies (such as an epi pen) to be kept on campus or a condition that increases the likelihood of a major medical event, please complete the emergency medical plan form on the back.***

I/We give Trinity Academy permission to share our child's medical information with others if it is deemed medically appropriate and/or will help keep them safe. I authorize the employees of Trinity Academy to consent on my/our behalf to any examination and/or medical diagnosis or treatment, including emergency or hospital care deemed advisable and rendered by a licensed physician, certified EMT or other agent until a parent or legal guardian is present. It is understood that this authorization is given in advance of any specific need and is given to provide advanced authority of such agents to consent to all diagnosis and treatment. I/We acknowledge that I/We will remain responsible for the cost of any treatment.

Student's Physician:	Phone #:		
Signature of parent/guardian:		Date:	
Printed name of parent/guardian:			