MT. JULIET CHRISTIAN ACADEMY EMERGENCY MEDICAL INFORMATION

Student Name ____
Last Middle First

Grade (2007-2008) ________ SS# ______________________ D.O.B ____________________

1. Mother/guardian

____
Name

____
Address

__________ __________ __________
Home # Work # Cell #

2. Father/guardian

____
Name

____
Address

__________ __________ __________
Home # Work # Cell #

3. Alternate Contact ______________________
Name

Check all that apply:

ADD/ADHD medication: ______________________

Allergies: ◊ Epi-pen ◊ Benadryl

Ashthma: ◊ Inhaler ◊ Nebulizer

Food allergy: ______________________

Diabetes:

____

Other: ______________________________

Insurance Company:

____

Policy #: ______________________________

For the _____________school year, I give permission to Mt. Juliet Christian Academy to use whatever emergency measures are judged necessary for the care and protection of my child while under their supervision. In the event of an accident, illness or other emergency needing medical attention, I hereby authorize MJCA to seek emergency medical care for my child. I understand that my child will be transported to an appropriate medical facility for treatment if the local emergency resource deems it necessary. I also give permission for the facility's assigned physician to evaluate and treat the condition. It is understood that in some medical situations, the school may need to contact the local emergency resource before the parent, child's physician and/or other adult acting on the parent's behalf.

Signature of parent/guardian ________________________________ Date
____

TRANSPORTATION PICK-UP INFORMATION FORM

*PLEASE NOTE: If a student is to be dismissed from school <u>EARLY</u> to anyone other than the parent we must have a note from parent or guardian even if the person picking up the student is on the PICK-UP form.

PLEASE LIST THE PEOPLE WHO ARE ALLOWED TO PICK UP YOUR CHILD FROM SCHOOL:

____
Name Phone#

____
Name Phone#

____

Name Phone#

~over~

SELF-CARRY MEDICATION AUTHORIZATION

(if applicable)

MJCA policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approval.

Condition for which the medication is administered:

____

Name of medication, dose and method administered:

____

Time or indication for administration:

____

Is this a controlled drug? _______ Yes ________ No

Side effects to be noted/reported:

____

Other recommendations:

____

Duration (dates) of administration: From _______________ to ________________ (limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

________________________________ ________________________________ ____________________ ____________

Physician Signature | Print Name | Telephone | Date

I request that my child, named above, be permitted to: ______ carry ______ self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date or original prescription; strength and dose of medication; and directions for use. No more than a 45 school day supply of medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.

_______________________________ ______________ __________________________________ ________________

Parent Signature | Date | Student Signature | Date

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contract the parent as soon as possible in the event.

_______________________________ ______________ __________________________________ ________________

School Nurse Signature | Date | Principal Signature | Date

ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

(if applicable)

The Tennessee State Law requires physician/dentist/APRN/PA's written order and the parent/guardian's authorization for a nurse to administer medications or, in her absence, the authorized staff to administer medications. Medications must be in pharmacy-prepared or original containers and labeled with the name of the student, name of the drug, strength, dosage, frequency, name of physician/dentist/APRN/PA, and the date of original prescription.

Name of medication: _________________________________ Dosage (amount): ____________ Time(s):

____

To be given from _______________________ to _______________________ How taken:___________________________

(date) (date)

Relevant side effects to be observed, if any: ________________________ If any, plan for management: __________________

____ ____

Physician Signature (required by law) Date

I request the above medication for my child __________________________, be administered by school personnel. I understand I must supply all medication to the school in the original container, properly labeled, and will provide no more than a 45 school day supply. Only medications that are medically necessary during school hours for a student's attendance should be sent to school. All medications will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

THE VERY FIRST DOSE OF MEDICATION MAY NOT BE GIVEN AT SCHOOL. Ask your pharmacist to prepare two labeled containers, one for school and one for home.

____ _______________________________________ ___________________________

Printed Name Signature Date