EMERGENCY NOTIFICATION, MEDICAL INFORMATION, AND STUDENT RELEASE INFORMATION

A. Student Name ____ **Date of Birth** ______________________

Address____

B. In case of emergency, illness or accident, please give an order of priority of who should be called:

NAME	HOME PHONE	WORK PHONE	CELL PHONE
1.			
2.			
3.			
4.			

C. Physician: ____ **Phone:** ______________________________

D. If this student has a specific medical, physical, or other condition that a teacher, counselor, or administrator should be aware of, please indicate below with any appropriate specific instructions that might be applicable. For example: asthma, reactions to medications, diabetes, seizures, allergies, physical limitations, etc. Attach any additional sheet if necessary.

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E. Acetaminophen or Ibuprofen and Cough Drop Permission:

The school may dispense **Acetaminophen** to my student upon his/her request **YES** **NO** (circle one)

The school may dispense **Ibuprofen** to my student upon his/her request **YES** **NO** (circle one)

The school may dispense **Cough Drops** to my student upon his/her request. **YES** **NO** (circle one)

Parent/Guardian Signature____ Date________________

Physician Signature (required) ____ Date ________________

F. Statement of Policy: Students may not leave school before completion of their regularly scheduled classes or leave a school-sponsored trip without the explicit written permission of the parent(s) or legal guardian(s). In case of illness students may not go home unless a parent or legal guardian has been contacted by the Deans' Office to pick the student up at school.

G. If there is someone this student ***should not be released to*** during school hours or during school- sponsored trips please indicate below. If this person is a non-custodial parent and there is a legal document involved, a copy of such is required by the school.

Name and relationship of person student **should not** be released to:

____

H. The undersigned has read and understands the statement of policy above. The undersigned also grants permission to the Deans of Students at Saint Ignatius College Prep or a designated representative to authorize any emergency treatment considered necessary by qualified medical personnel for the student whose name appears above. This authorization is for school days and at school sponsored events as stated in the school insurance policy while the student is in attendance at Saint Ignatius.

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Signature of Custodial Parent/Legal Guardian Date Signature of Parent/Legal Guardian Date

MEDICATION POLICY

All medication, whether prescribed or over the counter, must be kept in the Deans' Office. No medication is permitted to be carried on the student or taken at any location other than the Deans' Office with the exception of prescribed inhalers (see separate sheet regarding asthma inhalers) and EpiPens for severe allergies.

Medication will only be given to students who have a **parent and physician signature** on the medication form on file in the Deans' Office. ***This form must be updated annually.***

Prescription medication must be brought to the Deans' Office in pharmacy labeled containers and require a physician and parent signature. Over the counter medication must be in its original container, have an affixed label with the student's name and a physician and parent signature at the bottom of this form.

Tylenol/Acetaminophen and cough drops are stocked in the Deans' Office. It can only be dispensed to a student with a properly completed Emergency Notification, Medication form on file.

The parent must claim the remaining medication by the last day of the school year or it will be discarded.

MEDICATION CANNOT BE DISPENSED UNLESS THIS FORM IS COMPLETED

STUDENT NAME ____________________

HOME PHONE ____________________ **PARENT WORK PHONE** ____________________

DISEASE/ILLNESS ____________________

MEDICATION ____________________ **DOSE** ____________________

STRENGTH ____________ **FREQUENCY** ____________ **ROUTE** ____________

CONDITIONS UNDER WHICH IT SHOULD BE GIVEN: ____________________

____

POSSIBLE SIDE EFFECTS: ____________________

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Prescription medication should be labeled by the Physician or Pharmacist

Parent Signature ____________________ **Date** ____________

Physician Signature ____________________ **Date** ____________
(*REQUIRED FOR ALL MEDICATION*)