

ST. MARIA GORETTI SCHOOL
Emergency/Health

STUDENT: Last First Full Middle BIRTHDATE GRADE

Mother/Guardian Name Address (Street, City, Zip) Phone#

Father/Guardian Name Address (Street, City, Zip) Phone#

Mothers Employment Work Phone Mother's Cell

Fathers Employment Work Phone Father's Cell

Who does child live with _____

List other siblings/family members in household- include age

In case of an emergency, these people may pick up child if unable to reach a parent:

1. Name: _____ Phone _____ Relationship _____

2. Name: _____ Phone _____ Relationship _____

Hospital Preference _____ Child's Physician _____

Allergies: _____

Other medical conditions and/or daily medications (i.e. ADHD, Asthma, heart disease, Concerta): _____

In order to protect the health and welfare of the students and school staff, Indiana laws require that parents consent, in writing, to the administration of medication.

1. **The school nurse will have a limited supply of non-prescription (over-the-counter) medications. These medications will be given sparingly.**
2. **Non-prescription medication will only be given as instructed on the brand label, unless the school receives a written order from a physician authorizing the change. Only the school nurse can take a physician order over the phone or by fax.**
3. **For a non-prescription medication *that is not listed below*, you will need to obtain a physician's order and bring the order and the medication to the school nurse's office.**
4. **Medication brought to the school must be kept in the nurse's office in a locked cabinet. The medication must be in the original UNOPENED container with an outside label including the name of the medication and the age appropriate dose to be given. Please write your child's name and date on the container.**

My son/daughter may receive the medications checked below.

Yes	No	Medication	Dosage	Frequency
___	___	Tylenol (Acetaminophen)	per package instructions	as needed for headache, minor pain
___	___	Motrin/Advil (Ibuprofen)	per package instructions	as needed for headache, minor pain
___	___	Benadryl	per package instructions	Bee/Insect sting, allergic reaction
___	___	Menthol Throat Lozenge	per package instructions	as needed for sore throat or cough
___	___	Mylanta/Tums Tablets	per package instructions	as needed for minor upset stomach
___	___	Saline eye drops	1 or 2 drops	for itchy eyes or to dislodge debris
___	___	Hydrogen Peroxide	per package instructions	as needed for minor abrasions
___	___	Antibiotic Ointment	per package instructions	as needed for minor abrasions
___	___	Caladryl	per package instructions	as needed for itchy skin/itchy bites
___	___	Vaseline	per package instructions	as needed for dry or cracked lips
___	___	Sting Kill	per package instructions	as needed for bee/insect sting
___	___	Orajel.	Per package instructions	as needed for minor mouth sore
___	___	Burn Jel	per package instructions	as needed for minor burns

I authorize the St. Maria Goretti School nurse or school personnel under the supervision of the school nurse to be my agent to give medications checked above to my child. I hereby give my permission for St. Maria Goretti School to obtain needed medical services and transport to a hospital in case the named student suffers illness or accident requiring emergency services. If emergency services are required, parents/guardians and/or emergency contacts will be called at the phone numbers listed on this document.

Parent/Guardian signature _____ Date _____