West Meadows Baptist Academy
Student Medical Information and Authorization Form 2018-2019

Student's Name: _____ Date: _____

Parent(s) Name: _____ Home #: _____

Cell #: _____ Work #: _____ Email: _____

Student's Birth Date: _____/_____/_____ Grade (Entering): _____

Physician's Name: _____ Phone #: _____

Insurance Company: _____

Policy Number: _____ Primary Insured: _____

Does your child take any medication (prescription or non-prescription) on a routine basis? _____

If yes, is it to be taken during school hours? _____ If yes, what time is it to be given? _____

Name of medication: _____ Purpose of medication: _____

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My child has a medical condition that may affect his or her school day: □ No □ Yes (complete box below)

Check the box and explain if your child now or has a history of these condition(s).

□Asthma

*Students requiring a breathing treatment by nebulizer must have a parent come and administer it.

□Mild □Moderate □Severe □Exercise Induced □Weather Induced

□Rescue inhaler at home

□Rescue inhaler with student (*requires written physician authorization)

□Rescue inhaler in school office

Known allergy and asthma triggers include:

□Smoke □Dust □Other _____

□Diabetes

□Type I □Type II

□Self-managed □Requires assistance

□Insulin at home □Insulin at school

□Allergies to foods, insects, or medications

□Mild □Moderate □Severe

□EpiPen at home □EpiPen at school

□Bees/Insects _____ Reaction _____

□Foods _____ Reaction _____

□Medications _____ Reaction _____

□Other _____ Reaction _____

First symptoms may begin as (check all that apply):

□Itching and/or swelling of the lips, tongue, and/or mouth

□Itching and/or a sense of tightness in the throat, hoarseness, and/or hacking cough

□Hives, itchy rash, and/or swelling about the face and/or extremities

□Nausea, abdominal cramps, vomiting, and/or diarrhea

□Shortness of breath, repetitive coughing, and/or wheezing

□"Thready" pulse, passing out

□Other medical condition we should be aware of:

Please specify: _____

STUDENTS ARE NOT PERMITTED TO CARRY AND/OR SELF ADMINISTER MEDICATION. ALL MEDICATION MUST BE ADMINISTERED THROUGH THE SCHOOL OFFICE.

ACETAMINOPHEN, IBUPROFEN, ANTIHISTAMINE, ANTIBIOTIC AND/OR HYDROCORTIZONE CREAM, AND COUGH DROPS ARE AVAILABLE THROUGH THE OFFICE WITH WRITTEN PARENTAL AUTHORIZATION. IF AUTHORIZED, PLEASE INITIAL BELOW.

_____ It IS PERMISSIBLE to dispense Acetaminophen (Tylenol), 500 mg, _____ #tablets to the above named child.
_____ It IS PERMISSIBLE to dispense Ibuprofen (Motrin, Advil), 200 mg, _____ #tablets to the above named child.
_____ It IS PERMISSIBLE to dispense Antihistamine (Benadryl), 25 mg, _____ #tablets to the above named child.
_____ It IS PERMISSIBLE to dispense antibiotic (Neosporin) and/or hydrocortisone cream to the above named child.
_____ It IS PERMISSIBLE to dispense cough drops to the above named child.

I understand that no more than one dosage will be given in a day and that a note will be sent home when a dosage is given. If one dosage does not seem to help, I understand I will be called.

In the event of an emergency, and in the event I cannot be reached, I grant West Meadows Baptist Academy permission to act on my behalf in obtaining necessary medical treatment for my child.

Parent Signature: _____ Date: _____

STATE OF FLORIDA
COUNTY OF _____

Sworn to and subscribed before me this
_____ day of _____, 20_____,
by _____, who is personally known
or produced _____as identification.

(SEAL)

_____
Notary Signature