

**Trinity Christian Academy
Student Medical Information Form**

Student's Name _____ Student's DOB _____ Grade (Entering) _____

Does your child take any medication on a routine basis? Yes No During school hours

Name of medication: _____ Purpose of medication: _____

Name of medication: _____ Purpose of medication: _____

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 has now or has a history of these condition(s).

Asthma

Mild Moderate Severe Exercise Induced

Rescue Inhaler at home

Rescue Inhaler with student (*requires written physician authorization)

Rescue Inhaler in school clinic

Diabetes

Type I Type II

Self-managed

Requires assistance

Insulin at home

Insulin at school

Allergies to Foods, Insects or Medications

Mild Moderate Severe

Bees/Insects _____ Reaction _____

Foods _____ Reaction _____

Medication _____ Reaction _____

Other _____ Reaction _____

EpiPen at home EpiPen at school

Other Condition _____

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

➤ ACETOMINOPHEN AND IBUPROFEN ARE AVAILABLE THROUGH THE CLINIC WITH WRITTEN PARENTAL AUTHORIZATION. IF AUTHORIZED, PLEASE INITIAL BELOW.

_____ It IS PERMISSIBLE to dispense Tylenol (*Acetaminophen*) to the above named child.

_____ It IS PERMISSIBLE to dispense Ibuprofen (*Motrin, Advil*) to the above named child.

In the event of an emergency, and in the event that I cannot be reached, I grant a representative of Trinity Christian Academy permission to act in my behalf in obtaining necessary medical treatment for my child.

Parent Signature _____ Date _____

Primary Emergency Contact Name _____ Phone _____

Secondary Emergency Contact Name _____ Phone _____

Physician/Pediatrician's Name _____ Phone _____

Physician/Pediatrician's Office _____