Kingsport City Schools Medical Form

This form is required for ALL After School and School Related Activities

Additional forms will be needed if a student has a medical diagnosis of asthma, severe allergies or seizures. For additional information, contact the school nurse.

Student's Name: _____
(Last) (First) (Middle)

Student's Address: _____
(Number) (Street) (City) (State) (Zip)

Student's Date of Birth: _____ Grade: _____

Guardian 1's Name: _____ E-Mail: _____

Guardian 1's Address: _____

1st Phone #: _____ 2nd Phone #: _____ 3rd Phone #: _____

Guardian 2's Name: _____ E-Mail: _____

Guardian 2's Address: _____

1st Phone #: _____ 2nd Phone #: _____ 3rd Phone #: _____

****

Student's Healthcare Provider: _____ Phone #: _____

****

Health Insurance Company: _____

Insurance Company Address: _____

Group #: _____ID

Subscriber #: _____

Type of Insurance: Private_____ Group_____
No Medical Insurance at this time_____

****

PERSON TO NOTIFY IN CASE OF AN EMERGENCY AND YOU CANNOT BE REACHED
(Other Than Those Listed Above)

Name: _____ Home Address: _____

1st Phone #: _____ 2nd Phone #: _____ 3rd Phone #: _____

HEALTH HISTORY

Student's Name: _____ **Date of Birth**:_____

Drug Allergy *(List)* _____ **Food Allergy** *(List)* _____

Insect Bite Allergy ***(Life Threatening)*** _____**Latex Allergy** (circle) yes/no **Seasonal Allergies**_____

Epi-Pen required for Allergy? _____Other Medications used for Allergy_____

Asthma_____ **Inhaler required?** _____**Frequency used**? _____**Nebulizer required?** _____
Other Medical Problem(s) _____

Current Medications: _____

_____ **Last Tetanus Shot**: _____

Details of Treatment / Activities to be Restricted (*Requires Healthcare Provider's note):* _____

****

Medications/Parental Permissions

Permission for Over-the-Counter Medications

I represent that I am the guardian of the above child. I give my permission for KCS personnel to administer, or assist in the self administration of the parent-provided medications that I have initialed**.**

MEDICATIONS
(Initial each medication permitted to be administered if needed)

	Tylenol		Vaseline
	Ibuprofen		Artificial Tears
	Benadryl **(Emergency Use Only)**		Bausch & Lomb Eye Wash

Permission for Prescription and All Other Over-the-Counter Medications

Before administering any prescribed or over-the-counter medication (not on the approved list above) the school nurse must have the following:

- Completed Healthcare Provider Form for Administration of Medication for **each** medication (**over-the-counter & prescribed)** This form must be completed by the student's healthcare provider and signed by the parent/guardian.
- Each medication must be in the original, unopened container with the original label listing the ingredients.
- The student's name must be written on the container. Please note that students are not permitted to share any medications.

(The Healthcare Provider Form for Administration of Medication can be obtained from the school nurse and is good for one school year only).

Permission for Emergency Medical Treatment

- In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic.
- **Permission for Accompanying Physician:** I give permission for any physician who is present at any after school and/or school related activities to provide first aid/medical treatment to my child if necessary.

_____

(Parent / Guardian Signature) ***(Date)***