Emergency Medical Form

(REQUIRED, Page 1 of 2)

Student Name ______________________________

Address ______________ City ______________ State ________ Zip________

Date of Birth ______________ Male ❐ Female ❐ Grade _____ Phone ______________

Emergency Contact—please list the first and second person to attempt to contact in an emergency:

1. (name/relationship to student) ______________________________ **Phone** ______________

2. (name/relationship to student) ______________________________ **Phone** ______________

Mother's Name ______________ Daytime Phone ______________ Cell ______________

Employer/Address ______________________________ Phone ______________

Father's Name ______________ Daytime Phone ______________ Cell ______________

Employer/Address ______________________________ Phone ______________

Parents Address—if different from Student listed above. Mother ❐ **Father** ❐ (check one)

Address ______________ City ______________ State ________ Zip________

Phone: Home ______________ Work ______________ Cell ______________

List two other people who can be contacted in an emergency if the parent cannot be reached:

Name ______________________ Relationship to Child ______________

Address ______________ City ______________ State ________ Zip________

Phone: Home ______________ Work ______________ Cell ______________

Name ______________________ Relationship to Child ______________

Address ______________ City ______________ State ________ Zip________

Phone: Home ______________ Work ______________ Cell ______________

Medical Care:
Physician Name ______________________ Clinic Name ______________

Clinic Address ______________ City ______________ State ________ Zip________

Phone: Clinic ______________________ Physician's Emergency Phone ______________

Dentist Name ______________________ Clinic Name ______________

Clinic Address ______________ City ______________ State ________ Zip________

Phone: Clinic ______________________ Dentist's Emergency Phone ______________

Part I <u>or</u> Part II on back must be completed.

Part I or Part II below must be completed. Do not complete both. (REQUIRED, Page 2 of 2)

This form only authorizes St. Mark's Evangelical Lutheran School to secure transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility set their own treatment procedure.

Part I. Permission to Transport Child

I give St. Mark's Evangelical Lutheran School my permission to transport my child (name)____
to (hospital/clinic) ____for emergency medical care; or to (dentist/dental clinic) ____for emergency dental care,or to the nearest available source of assistance.

Signature of Parent ____ Date_______________

OR

Part II. Refusal to Grant Permission

I do not give permission to St. Mark's Evangelical Lutheran School to transport my child (name)____for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken:____

Signature of Parent ____ Date_______________

Photo Release Form for Minors

(REQUIRED)

****Complete separate forms for each child.****

I, being the parent/guardian of (name of child)______________________________, hereby consent that the photographs or videos taken of my child and/or schoolwork completed during the school year while enrolled as a student may be used as indicated below.

Please read carefully and check the appropriate boxes. If boxes are not checked, you are stating that we CAN use your child's photo, video, and schoolwork. Online use will not include personal identification of any student by name.

I approve of use of my child's photo, video, or schoolwork in the following ways:

School Bulletin Boards & Newsletters	☐ **Yes**	☐ **No**
Local Newspapers	☐ **Yes**	☐ **No**
School Brochures	☐ **Yes**	☐ **No**
Facebook	☐ **Yes**	☐ **No**
Website	☐ **Yes**	☐ **No**

Name of Student: ____ Grade: __________________

Signature of Parent: ____

Please sign and return this to the school office. This paper will be kept on file in the school office for only one year. Parents need to be sign a permission slip every year that their child is enrolled in school. Parents always have the right to update and change this at any time during the school year.

Daily Pickup Permission Form

(REQUIRED)

The following individuals are permitted to transport my child(ren) to/from St. Mark's Lutheran School. I understand that in some circumstances they may be required to identify themselves when not recognized by staff members. I further understand that individuals picking up students at times other than regular dismissal will be required to follow sign-out procedures in the school/church office prior to taking custody of the child(ren).

Child's Name ___________________________ Class ______________

___________________________ ______________

___________________________ ______________

___________________________ ______________

Names of individuals transporting child	**Phone #**	relationship to child

-- --------------------------------

Parent's signature Date

Student Medical Form (*REQUIRED)

St. Mark's Lutheran School, 5849 Buckwheat Rd. Milford, Ohio 45150
Phone: 513-575-3354 Fax: 513-575-2472

***Required every year for all Preschool Students.**
***Update Required for all Kindergarten, 7th Grade, and NEW Students.**
(Updated forms not required for 1st–6th and 8th grade returning students.)

Student's Name ______________________________

Class __________ Birthday ______________________________

Parent's Name ______________________________

Please complete the identifying information and records or have your child's doctor fax the child's medical history to the school.

DTaP 1 ________ 2 ________ 3 ________ 4 ________ 5 ________

Polio 1 ________ 2 ________ 3 ________ 4 ________ 5 ________

HIB 1 ________ 2 ________ 3 ________ 4 ________

Hepatitus B 1 ________ 2 ________ 3 ________

MMR (measles, mumps, rubella) 1 ________ 2 ________

Varicella 1 ________ 2 ________

7th Grade Only: Tdap ________ Meningococcal MCV4 ________

The 5th DTaP and 4th polio are normally administered just prior to kindergarten

REQUIRED

THIS SECTION MUST BE COMPLETED BY PHYSICIAN

Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care. **YES** **NO**

List any limitations or health conditions ______________________________

____

Date of exam ______________________________ **(Expires after one year)**

Physician's Name ______________________________

Address ______________________________

Phone number ______________________________

Physician's Signature ______________________________

Student with Existing/Identified Health Problem (only if applicable)

Student Name ____

Address ____________________________ City ____________________ State ____________ Zip____________

Date of Birth ____________________ Male ❐ Female ❐ Grade ______ Phone________________________

This form is for students with identified health problems such as: asthma, seizures, hemophilia, etc., and will be placed in the students file and a copy provided to the teacher.

Condition: ____

Symptoms: (State most obvious signs that would appear if student were having difficulty)

1. ____
2. ____
3. ____

Immediate Action: (State action necessary to be taken to best respond to student immediate needs)

1. ____
2. ____
3. ____

Secondary Action: (Once immediate crisis is past, persons to call, signs to watch for, etc.— if none state none)

1. ____
2. ____
3. ____

Mother's Name__________________________Day Phone _________________________ Cell ___________________

Father's Name __________________________Day Phone _________________________ Cell ___________________

Please list two available alternates to attempt to contact in an emergency:

1. (name/relationship to student) ____ Day Phone ___________________
2. (name/relationship to student) ____ Day Phone ___________________

Physician Name _________________________Clinic Name____

Phone: Clinic ________________________________ Physician's Emergency Phone ______________________________

Dentist Name___________________________Clinic Name____

Phone: Clinic __________________________________ Dentist's Emergency Phone ______________________________

Dispensing Medication at School

(Only if applicable, Page 1 of 2)

Address ______________________ City________________ State ________ Zip__________

Date of Birth ____________ Male ❒ Female ❒ Grade _____ Phone __________________

It is recognized that some students must take medication during school hours. Parents are encouraged to administer medication before and after school whenever possible. If this is not possible, school personnel will provide necessary assistance; however, St. Mark's Evangelical Lutheran Board of Christian Education policy requires consent of a parent before medication can be given to a child by school personnel. The following information is necessary in order to comply with this policy. Return this form to the child's principal.

To Be Completed By The Child's Physician:

I have prescribed during the school day: **Student Name** ______________________________

Name of Medication (as it appears on container in which the drug is stored):______________________________

Dosage: ______________________________

Duration of Dosage:______________________________

How administered: ______________________________

Date to begin administering medication: ______________________________

Date to terminate administering medication: ______________________________

Possible adverse reactions to be reported to physician: ______________________________

List any special conditions for storage of drug: ______________________________

____

Name of Physician:______________________________

Primary Phone: ____________________Physician's Emergency Phone: ____________________

Physician's Signature: ______________________________Date:____________________

The medicine must be in pill, capsule, or spoon form. It must be in a clearly marked container from the pharmacist. The label must show the child's name, the dosage directions, the doctor's name, and the prescription number.

To Be Completed By The Parent:

Pharmacy: ______________________________ Phone:____________________

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

This permission is no longer valid at the end of the current school year.

I give my permission for the principal or his/her designee to administer the prescribed medication.

Signature of Parent: ______________________________Date:____________________

Name of Student: ____________________

Medication: ____________________

Date	Time	Comments	Name

Allergy Action Plan

(only if applicable)

Student Name ______________________________

Address ____________________ City ________________ State __________ Zip __________

Date of Birth ________________ Male ❒ Female ❒ Grade ______ Phone ________________

Allergy Information

Student is Allergic to: ______________________________

Student's reaction includes the following: (x the ones that apply)

❒ Confusion
❒ Difficulty Breathing
❒ Dizziness
❒ Drooling Or Difficulty Swallowing
❒ Flushed Face
❒ Itchy, Sneezing, Runny Nose
❒ Loss Of Consciousness
❒ Hives All Over Body
❒ Paleness
❒ Rash
❒ Red, Watery Eyes
❒ Seizures
❒ Several Hives On One Part Of Body
❒ Weakness
❒ Other: ________________ ____

How often is your child medicated for allergy? ______________________________

Should medication be available at school? Yes ❒ No ❒
(If the answer is yes, a "Dispensing Medication at School" form must be on file and medication must be provided by the parents in its original container)

Please list the steps you would like school personnel to follow, in the event of an allergic reaction or emergency situation. (Include phone numbers—any medication that needs to be given must be provided by the family.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

Signature of Parent ______________________________

Mother's Name ________________ Day Phone ________________ Cell ________________

Father's Name ________________ Day Phone ________________ Cell ________________

Please list two available alternates to attempt to contact in an emergency:

1. (name/relationship to student) ______________________________ Day Phone ________________

2. (name/relationship to student) ______________________________ Day Phone ________________

Physician Name ________________ Clinic Name ______________________________

Phone: Clinic ________________ Physician's Emergency Phone ________________

Dentist Name ________________ Clinic Name ______________________________

Phone: Clinic ________________ Dentist's Emergency Phone ________________

Asthma Action Plan

(only if applicable)

Student Name ____________________

Address ____________ City ____________ State ________ Zip ________

Date of Birth ____________ Male ❒ Female ❒ Grade ______ Phone ____________

Student Asthma Information

1. Does your child have asthma that has been diagnosed by a doctor? Yes ❒ No ❒
2. Is your child's asthma severe enough to require him/her to carry their inhaler with them? Yes ❒ No ❒
   (If Yes, a physician must write an order indicating so along with the "Dispensing Medication at School" form must be on file)
3. Does you child have any known "trigger" factors? Yes ❒ No ❒
   If Yes please list:

1. ____________ 2. ____________ 3. ____________

Asthma Emergency Action

The following are possible signs of an asthma emergency:

1. Difficulty breathing, walking, or talking
2. Blue or gray discoloration of the lips or nail beds
3. Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

1. Activate the emergency medical system in your area: 911
2. Call the parent or physician

Medications to be given at school—if any, the "Dispensing Medication at School" form must be on file)

1. Name ____________ Dosage ____________ Time ____________

2. Name ____________ Dosage ____________ Time ____________

Steps to be taken for an acute asthma episode:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Signature of Parent ____________________

Mother's Name ____________ Day Phone ____________ Cell ____________

Father's Name ____________ Day Phone ____________ Cell ____________

Please list two available alternates to attempt to contact in an emergency:

1. (name/relationship to student) ____________ Day Phone ____________
2. (name/relationship to student) ____________ Day Phone ____________

Physician Name ____________ Clinic Name ____________

Phone: Clinic ____________ Physician's Emergency Phone ____________