



CLASS OF 2021 Medical Form

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination, or immunizations for the above named student. In the event of serious illness, or significant injury, or the need for major surgery, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named student may be given.

Medication Information: (Check All that Apply)

- ☐ **This student takes no medication** and will bring no medication with him/her.
- ☐ **This student takes medication/s** and will self-medicate. The student will bring all such medications necessary, and such medications will be clearly labeled. I understand that the student will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be this student's responsibility to present him/her at a location designated for returning medication(s) to this student at the frequencies/times listed below. I understand that the adult to whom this student surrenders the medication has no medical training and this adult will not measure dosages. This student will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be this student's responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies/times are as listed below: (you may attach a sheet to this form if you need more space just make sure to sign and date it as well)
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- ☐ **This student takes medication** but is unable to self-medicate. The student's parent/guardian/conservator will provide and dispense any and all needed medications.
- ☐ **No medication of any type** whether prescription or nonprescription may be administered to this student unless the situation is life-threatening and emergency treatment is required.
- ☐ **I grant permission** for the following nonprescription medication to be given to this student (EXCLUDING MEDICATION LISTED BELOW THAT CAUSES ALLERGIC REACTION).

Non-aspirin pain reliever Yes_____ No_____ # of tablets per dosage_____. Throat Lozenge Yes_____ No_____

Decongestant Yes_____ No_____ # of tablets per dosage_____. Antacid Yes_____ No_____

Antihistamine Yes_____ No_____ #of tablets per dosage_____.

Specific Medical Information

Allergic reactions (medications, foods, plants, insects, etc.) _____

Immunizations: date of last tetanus/diphtheria immunization _____

Other Medications student currently takes _____

Any physical limitations _____

Has student recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? Please note date and disease or condition. _____

You should also be aware of these **special medical conditions** and/or **SPECIAL DIETARY REQUIREMENTS**.

- ☐ **I have attached** additional information in regards to my student's medical information.

Signature of Parent/Guardian/Conservator: _____ **Date:** _____

Printed Name of Student: _____

Signature of Student: _____ **Date:** _____