



MEDICAL PERMISSION AND RELEASE FORM 2018-2019

CHILD #1 _____ AGE _____ GRADE _____

CHILD #2 _____ AGE _____ GRADE _____

CHILD #3 _____ AGE _____ GRADE _____

CHILD #4 _____ AGE _____ GRADE _____

Family Physician _____ Ph # _____

Insurance Company _____ Policy # _____ Policy Holder Name _____

DIETARY PREFERENCE: _____

KNOWN ALLERGIES / MEDICAL CONDITIONS

CHILD # 1 _____
 FOOD PENICILLIN/DRUGS INSECT STINGS/BITES PREVIOUS SERIOUS ILLNESSES CURRENT MEDICATIONS
 SPECIAL DIET _____

CHILD # 2 _____
 FOOD PENICILLIN/DRUGS INSECT STINGS/BITES PREVIOUS SERIOUS ILLNESSES CURRENT MEDICATIONS
 SPECIAL DIET _____

CHILD # 3 _____
 FOOD PENICILLIN/DRUGS INSECT STINGS/BITES PREVIOUS SERIOUS ILLNESSES CURRENT MEDICATIONS
 SPECIAL DIET _____

CHILD # 4 _____
 FOOD PENICILLIN/DRUGS INSECT STINGS/BITES PREVIOUS SERIOUS ILLNESSES CURRENT MEDICATIONS
 SPECIAL DIET _____

AUTHORIZATION FOR ADMINISTRATION OF O.T.C. MEDICATIONS

CHILD #1 _____	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Cough Drop
	<input type="checkbox"/> Neosporin	<input type="checkbox"/> Benadryl Spray	
CHILD #2 _____	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Cough Drop
	<input type="checkbox"/> Neosporin	<input type="checkbox"/> Benadryl Spray	
CHILD #3 _____	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Cough Drop
	<input type="checkbox"/> Neosporin	<input type="checkbox"/> Benadryl Spray	
CHILD #4 _____	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Cough Drop
	<input type="checkbox"/> Neosporin	<input type="checkbox"/> Benadryl Spray	

I HEREBY AUTHORIZE NAPLES CHRISTIAN ACADEMY TO TAKE MY CHILD TO ANY HOSPITAL OR LICENSED PHYSICIAN FOR MEDICAL TREATMENT IN THE EVENT OF AN EMERGENCY IN WHICH NEITHER PARENT CAN BE REACHED.

Parent/Guardian Printed Name

Parent/Guardian Signature

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN OR MEDICAL TREATMENT CENTER TO TREAT MY CHILD IN CASE OF AN EMERGENCY IN WHICH NEITHER PARENT CAN BE REACHED.

Parent/Guardian Printed Name

Parent/Guardian Signature

Prescription Medication Policy – NOTE - Prescription medication MUST be in the original container with a label showing the prescribed dosage and name of student. For insurance liability reasons, students are not permitted to administer their own medications.

Student Name _____

Prescription Medication _____

Time to be administered _____ a.m. _____ p.m.