MEDICAL PERMISSION AND RELEASE FORM
2020-2021

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 ______________________________________ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop ❒ Neosporin ❒ Benadryl Spray

CHILD #2 ______________________________________ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop ❒ Neosporin ❒ Benadryl Spray

CHILD #3 ______________________________________ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop ❒ Neosporin ❒ Benadryl Spray

CHILD #4 ______________________________________ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop ❒ Neosporin ❒ Benadryl Spray

Please complete the back of this form

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.

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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.

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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.