STUDENT MEDICAL CONSENT FORM

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Medication/Prescription Authorization

Student's Name: _____ Date:_____

Name of Medication: _____Reason for Taking:_____

Dosage:_____Route:_____Frequency/Times to be Given:_____

Start administration of medication beginning _____ Discontinue:_____

Special Instructions:

Requires Refrigeration? Yes_____ No_____

Is medication a controlled substance? Yes_____ No_____

Is self-medication permitted and recommended by physician? Yes_____ No_____

Is this an emergency medication to be kept in student's possession? Yes_____ No_____

Potential side effect/contraindications/adverse

reactions:_____

_

_____

Treatment in the event of an adverse reaction:

_____

_____

Signature of Prescriber :_____ Date:_____

Phone Number:_____

Parent Authorization:

I authorize school personnel to assist my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Medication must be registered with the student's teacher. It should be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval between dosages, route of administration, and the date the medication will expire.

_____

Signature of Parent or Guardian Date Phone #

I authorize and recommend self- medication by my child for the above medication.

_____

Signature of Parent or Guardian Date Phone #

If any questions or problems arise, call me at :_____

Medical Information

Parents will automatically be notified in case of an emergency. Please provide another emergency contact person.

Name:_____ Relation_____Phone:_____

Family Doctor _____ Phone: _____

Continuing Consent to Treatment and Authorization to Release Information

We, the undersigned parents of guardian of the afore-mentioned student, a minor, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general or special instructions of our doctor any physician the school or organization may call, whether such diagnosis or treatment is

rendered at the office of said licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the school or other organization. It is further understood that this consent is given in advance of any specific diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school or organization entrusted with the custody of said minor. We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the school insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostat copy of this authorization shall be considered as effective and is valid as the original.

Father_____Mother _____

Legal Guardian_____

Witness_____ Date:_____

References:

Give the names and addresses of at least two references

_____

Name Address City/State Phone

_____

Name Address City/State Phone

Student Contract

I have read the objectives, standards and policies of this school. If I am accepted, I will endeavor at all times to uphold the Christian standards of the school and to respect staff members.

_____

SignatureofStudent Date

Parent/Guardian Contract

I am in agreement with the objectives, standards, and policies of New Creative Works School. I will support the school and staff and upon my child's admission, I accept full financial responsibility for the above student.

_____

Signature of Parent /Date