SUSSEX CHRISTIAN SCHOOL

MEDICAL INFORMATION

Need one for each student

One copy of this page is to be completed for each student being enrolled.

STUDENT INFORMATION

First Name:

Middle Name:

Last Name:

Local Physician's Name (If applicable):

Medicare #:

Medicare Expiry Date:

Does applicant have any mental, emotional, physical limitations, or learning disabilities that may affect his/her activities or progress, or for some reason should be known by his/her teachers?

Please specify if your child has any allergies:

Specify if your child requires regular medication to be administered at school:

NOTE: If medication is required on a regular basis, or at a specified time, medication must be brought to the school office, labeled with child's name and dosage requirements, and a medical permission form must be completed.

By signing this form, I understand that Sussex Christian School is not responsible for any injury or harm that may occur as a result of this medication. Sussex Christian School reserves the right to revoke this privilege if it is being abused (constant use of pain medication, etc.). ***In order to receive pain medication, students must check with their Home Room teacher before coming to the school office for such medication.***

My child will be permitted to be given the following pain medication(s) during school hours if necessary, understanding that this does not mean they are allowed to abuse this privilege. (Please check all allowable ones)

- ☐ Aspirin (ASA)
- ☐ Tylenol (Acetaminophen)
- ☐ Advil (Ibuprophen)
- ☐ My child is not permitted to receive any pain medications

EMERGENCY MEDICAL TREATMENT

☐ I hereby authorize Sussex Christian School to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical aid and surgical care in the case that I, or the designated guardian, am not immediately available. Any qualified physician, called by SCS, may treat and do whatever is necessary for the health and well-being of my child. It is understood that a conscientious effort must be made to notify me before such action will be taken. I also agree to accept responsibility for the cost of above medical services

By signing below, I signify that I have read and understand the above policy.

Signature of Father/Guardian

Signature of Mother/Guardian

Date

Date