AMERICAN HERITAGE/ AMERICAN ACADEMY SCHOOL *of* BOCA-DELRAY
HEALTH SERVICES FORM & EMERGENCY CONSENT
PERSONAL AND CONFIDENTIAL

In order for our staff to properly care for your child we ask that this form be completed on both sides and returned no later than: **June 4, 2012- Camp or August 29, 2011- School**
The REVERSE SIDE of this form MUST be completed by Student/Camper's Physician: ***Physician Authorization***
~NOTE~ Without PHYSICIAN"S SIGNATURE and STAMP~ Off Campus activities will be restricted.

(CIRCLE) **CAMP/ AH/ AA** **GRADE:_____** **CAMP:** WK1___ WK2___ WK3___ WK4___ WK5___ WK6___ WK7___ WK8___ WK9___

STUDENT/CAMPER NAME: ______________________________ **M/F** Ht: ____Wt: ____
LAST FIIRST MI

ADDRESS: ______________________________ **DATE OF BIRTH** ____________
STREET APT#

______________________________ PHONE: ______________
CITY STATE ZIP

STUDENT/CAMPER RESIDES WITH: _____ MOTHER _____ FATHER _____BOTH _____OTHER

MOTHER/GUARDIAN:
NAME: ______________________ EMAIL: ______________________
ADDRESS: ______________________________
PHONE: (HOME) ______________ (CELL) ______________ (WORK) ______________

FATHER/GUARDIAN:
NAME: ______________________ EMAIL: ______________________
ADDRESS: ______________________________
PHONE: (HOME) ______________ (CELL) ______________ (WORK) ______________

EMERGENCY CONTACT INFORMATION: (THE STAFF WILL CALL THESE NUMBERS IN THE ORDER LISTED)
In case of an emergency, illness, or accident, the school is authorized to make the following contact if parent is unavailable:
1. ______________ RELATION: __________ PHONE: (H)__________(C)__________
2. ______________ RELATION: __________ PHONE: (H)__________(C)__________
3. ______________ RELATION: __________ PHONE: (H)__________(C)__________

PHYSICIAN'S NAME: ______________________PHYSICIAN'S PHONE______________
DENTIST: ______________________DENTIST'S PHONE______________
MEDICAL INSURANCE CARRIER: ______________________ POLICY#:______________

STUDENT MEDICAL INFORMATION: *(Please complete carefully and completely)*
The health services at American Heritage/American School are to provide immediate first aid, administer and provide short-term care to students until a parent or designated Emergency Contact can pick up the student. A diagnosis cannot be made, nor are there facilities for extended periods of bed rest. We ask your cooperation in keeping sick children at home to prevent the spread of contagious illness.
CURRENT MEDICAL PROBLEMS: (ASTHMA, DIABETES, ANEMIA, HEADACHES, AND ANY OTHER PROBLEMS PERTINENT TO THE STUDENT'S CARE)
____
____
ALLERGIES: (MEDICATIONS/FOODS) ______________________________
MEDICATIONS CURRENTLY TAKING: ______________________________
____

DOES YOUR CHILD HAVE ANY RESTRICTIONS ON HIS/HER ACTIVITIES? ___YES ___NO
DOES YOUR CHILD HAVE ANY HEALTH NEEDS WHICH REQUIRE NURSING CARE DURING SCHOOL HOURS? ___YES ___NO
If you answered YES to any of the questions above,
explain: ______________________________
____

The school nurse has my permission to share my child's information with his/her teachers: ___YES ___NO

If I cannot be reached, I hereby give American Heritage/American Academy permission for emergency medical treatment, hospitalization, anesthesia, x-rays, or necessary injections for my child and I assume responsibility for payment of bills incurred. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity for surgery are obtained prior to the performing of such surgery. ***(Both parents or custodial parent must sign below)***

Mother/Custodian Signature: ______________________________ Date: ______________

Father/Custodian Signature: ______________________________ Date: ______________

If you have any questions or concerns please contact the clinic at 561.495.7272 ext.223.
This information will be filed in the onsite Campus Clinic with the Nurse. Information will be valid through August 31, 2012

STUDENT'S NAME: ____DATE OF BIRTH: ____________

PARENT CONSENT *(TO BE COMPLETED BY PARENT/GUARDIAN)*

I grant the nurse, head of school or his/her designee the permission to assist or perform the administration for each medication (prescribed and/or over-the-counter) or treatment/procedure for my child during the school day including when he/she is away from school property for official school events. Please NOTE:

- Medications must be supplied in the original container. Ask the pharmacist to divide medication into 2 labeled containers, one for home and one for school
- Only medications/treatments authorized by a physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication/treatment regime.

I understand that (1) there is no liability on the part of the school, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it not picked up within one week following the stop date or one week after the close of the current school year, or when the medication prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

Mother/Custodian Signature: ____Date: ______________

Father/Custodian Signature: ____Date: ______________

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MEDICAL HISTORY: (Please list all Medications taken at home or during the school year)

ALLERGIES:___NO ___YES LIST:____

MEDICATION:____

ASTHMA: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

AUTISM: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

ADD or ADHD: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

CARDIAC DISORDERS: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

DIABETES: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

RECENT SURGERY: ___NO ___YES EXPLAIN: ____

DATE:__________________MEDICATION:______________________________

SEIZURE DISORDER: ___NO ___YES EXPLAIN: ____

MEDICATION: ____

PHYSICIAN'S AUTHORIZATION FOR MEDICATION/TREATMENT *(TO BE COMPLETED BY PHYSICIAN)*

Please CROSS OFF MEDICATIONS the student MAY NOT have, and enter any additional medications needed.

MEDICATION	DOSAGE	ROUTE & FREQUENCY	INDICATIONS FOR USE
Acetaminophen (Tylenol)	PO	Per bottle instructions	Headache or fever
Bacitracin Antibiotic Ointmnet	TOPICAL	Per bottle instructions	Cuts and abrasions
Benadryl Elixir	PO	Per bottle instructions	Allergic reactions
Benadryl Gel	TOPICAL	Per bottle instructions	Itching or bug bites
Hydrogen Peroxide	TOPICAL	Per bottle instructions	Antiseptic care
Hall's Cough Drops	PO	Per bottle instructions	Cough or sore throat
Ibuprofen (Advil/Motrin)	PO	Per bottle instructions	Headache, general pain
Luden's Throat Lozenges	PO	Per bottle instructions	Sore throat
TUMS	PO	Per bottle instructions	Stomachache
Vaseline	TOPICAL	Per bottle instructions	Eczema, lips

DIAGNOSIS **ORDERS- (*Issued by United States Licensed Physician)***

1. ____ ____

____

Side Effects & Specific Instructions: ____

2. ____ ____

____

Side Effects & Specific Instructions: ____

______________________________ ______________________________ ____________

PHYSICIAN'S NAME *(PRINT)* **SIGNATURE AND STAMP (*REQUIRED*)** **DATE**