AMERICAN HERITAGE SCHOOL / AMERICAN ACADEMY / SUMMER DAY CAMP

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: **August 23, 2010 – School OR May 1, 2011 – Summer 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 ◆

Grade: ________ AH / AA 2011 Summer School Session I _____ Session II _____ Session III _____
2010 / 11 School Year

Student/Camper Name____D.O.B.____________PIN_________
Last *First*

Address____ Weight_____Height______
Street *City* *ST* *Zip Code*

In Case of Emergency, the Staff will call these numbers in the order listed:

Mother's Name________________________________Home Phone___________________Cell______________________
Father's Name_________________________________ Home Phone___________________Cell_______________________
Other_________________________________Home/Cell___________________Relation To Camper___________________
Other_________________________________Home/Cell___________________Relation To Camper___________________

Health Insurance: YES___NO___ Insurance Carrier______________________________Policy#__________________

Physician's Name________________Phone#___________Dentist's Name_______________Phone#____________

The health services at American Heritage/Academy School/Summer Day Camp are to provide immediate first aid, administer medication and provide short term care to students/campers 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.

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 yes, please specify: ____
____

The school nurse has my permission to share my child's health information with his/her teachers/counselors: Yes ______ No _______

TO BE COMPLETED BY THE STUDENT/CAMPER'S PARENT/GUARDIAN

I grant the nurse, head of school/camp or his/her designee the permission to assist or perform the administration for each medication or treatment/procedure for my child during the school/camp day including when he/she is away from school/camp property for official school/camp events.

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/camp.
* Only medications/treatments **authorized by a physician** may be administered by school/camp personnel.
* It is your responsibility to notify the school/camp when there is a change in medication/treatment regime.

I understand that (1) there is no liability on the part of the school/camp, 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 or similar 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 is not picked up within one week following the above stop date or one week after the close of the current school year/camp session, or when prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and campus health personnel.

__________________________________ __________________________________ ____________________
Parent/Guardian Name **Signature of Parent/Guardian** **Date**

If you have any questions or concerns please contact the clinic at 954-472-0022, Ext. 3071

If I cannot be reached, I give American Heritage School/American Academy/Summer Day Camp permission for emergency medical treatment, hospitalization, anesthesia, or necessary x-rays or injection, and will be responsible for the bills of same. This authorization does not include major surgery, unless life threatening, and only then when the medical opinion of two(2) licensed physicians or dentists concur in that treatment. I give my permission for the clinic staff/designee to administer approved medications to my child(ren). ***(Both Parents or Custodial Parent must sign below.)***

X Mother/Custodian ____ ___________________________
Signature **Date**

X Father/Custodian ____ ___________________________
Signature **Date**

This information will be filed in the onsite Campus Clinic with the Staff Nurse.

Information will be valid for one (1) year

AMERICAN HERITAGE SCHOOL / AMERICAN ACADEMY / SUMMER DAY CAMP

PHYSICIAN AUTHORIZATION FOR MEDICATION AND NURSING CARE

PERSONAL AND CONFIDENTIAL

PHYSICIAN'S SIGNATURE & STAMP REQUIRED BELOW

By **Law**, we are unable to administer **ANY** medicines or over-the-counter remedies without the authority of a physician. If your child needs to receive his/her prescription medicine during school/camp hours, they must arrive in a pharmacist's container, where the label clearly states the child's name, the name of the medicine, the dosage, and the frequency of the dose. The Clinic Nurses will provide name-brand, over-the-counter comfort remedies for the child with this completed Authorization, **signed and stamped** by your child's physician.

◆NOTE – Without PHYSICIAN'S signature and stamp – Off-Campus activities will be restricted ◆

STUDENT NAME: ______________________________ **DOB:** ________________.

Medical History: (Please list all Medications taken at home or during the school year)

Allergies: YES___ List______________________________ NO___
*Medication*______________________________

Asthma: YES___ Explain______________________________ NO___
*Medication*______________________________

Autism: YES___ Explain______________________________ NO___
____
*Medication*______________________________

ADD or ADHD: YES___ Explain______________________________ NO___
____
*Medication*______________________________

Cardiac Disorders: YES___ Explain______________________________ NO___
*Medication*______________________________

Diabetes: YES___ Explain______________________________ NO___
*Medication*______________________________

Recent Surgery: YES___ Explain______________________________ NO___
Date____________*Medication*______________________________

Seizure Disorders: YES___ Explain______________________________ NO___
____
*Medication*______________________________

List any allergy and diagnosis, or emergency precautions that The Clinic should anticipate for this child, i.e.: allergy triggers, diabetic reactions, etc. List all medications that are currently prescribed for this child. Include inhalers, Epipens, etc.

DIAGNOSIS **ORDERS –** ***Issued by United States licensed Physician***

1. ______________________________ ______________________________
____

Side Effects & Specific Instructions ______________________________
____

2. ______________________________ ______________________________
____

Side Effects & Specific Instructions ______________________________
____

◆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 Oint.	Topical	per package 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		antiseptic care
Hall's Cough Drops	po	per package instructions	cough or sore throat
Ibuprofen (advil/motrin)	po	per bottle instructions	headache,general pain
Luden's Throat Lozenges	po	per package instructions	sore throat
Tums	po	per bottle instructions	stomach ache
Vaseline	Topical	per package instructions	eczema, lips

______________________________ ______________________________ ______________________________

PHYSICIAN'S NAME PRINTED **PHYSICIAN'S SIGNATURE / DATE** **PHYSICIAN'S STAMP – REQUIRED**