CHRIST SCHOOL

500 CHRIST SCHOOL RD, ARDEN, NC 28704

MEDICAL TREATMENT FORM

Student Name: **Date of Birth:**

Student Cell#: SSN#:

Drug allergies/reaction:

Food allergies/restriction:

Seasonal/environment allergies:

Primary MD: **Contact Phone Number:**

Parent(s)/Guardian(s) Contact Information (please print):

1. Name: Cell #: Other#:

Billing address: Email:

2. Name: Cell #: Other#:

Billing address: Email:

Emergency Contact Information if parent/guardian is unavailable (please print):

1. Name: Cell #: Other #:

2. Name: Cell #: Other #:

AUTHORIZATION FOR MEDICAL TREATMENT/IMMUNIZATIONS:

In the event of accident or illness, I hereby authorize Christ School personnel to act on my behalf as the legal guardian for the student named above in securing of medical, surgical, psychiatric, and/or dental treatment. In the event of an emergency, I hereby give permission to the physician, nurse, hospitals, hospital staff, emergency medical/rescue squad, local urgent care center, and doctor's office selected by Christ School nursing staff / personnel to act on my behalf. I authorize Christ School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student named. I certify that I am the parent or have the legal ability to sign these authorizations on behalf of the student named above. I consent to the release of information to Christ School and to the insurance company. I am financially responsible for all medical treatment and release Christ School from any financial liability.

1. Parent/Guardian(s) name (sign): date:

2. Parent/Guardian(s) name (sign): date:

PLEASE PROVIDE FRONT AND BACK COPY OF MEDICAL/DENTAL/RX INSURANCE CARDS

Primary Insurance Cardholder's (*PIC*) Name:

PIC*'s DOB**: ***PIC*'s SSN # xxx-xx-** ***Group ID:

CHRIST SCHOOL

MEDICATION POLICY AND PARENT PROCEDURE ACKNOWLEDGEMENT

1. **I understand NO prescription or over-the-counter medications will be permitted in my son's possession (excluding emergency inhalers, Epi-pens, face creams, & insulin) unless provided through the Wellness Center. Non-compliance will be reported to the Student Life Office.**

2. It is **MY** responsibility to ensure **MY** son's MD will mail and/or fax all prescription orders to the school pharmacy (Cane Creek Pharmacy). It is also my responsibility to provide insurance and payment information to allow prompt dispensing. If choosing to use an alternative pharmacy, all responsibilities for providing medication in a timely manner is parent's responsibility.

3. **I understand students may not transport controlled substances off campus for Breaks, including weekends, without written permission** and I, the parent, assume full responsibility when he does so. When students are being transported by Christ School, the driver will take/pick up medications to/at the destination directly to/from the parent/guardian. If student is traveling by air, the driver will transport his medication to the airport and give to the student at the airport for packing in luggage or carry-on.

4. If my son is visiting with a family/sponsor over a weekend or Break, I give permission for hosting families to receive medical treatment/release form and medications prescribed for the duration of my son's visit.

5. For prescribed medications, a Medication Authorization form will be completed and signed by a physician for each of my son's medications. **I acknowledge all medications and/or changes in medication must be approved by the physician before being administered or discontinued.**

6. If a medication must be sent to school, it will be mailed **directly to Attn: Wellness Center. (Please do not send to your son's address.)**

7. **All medications not requested by the parent within 30 days of illness, injury, or discontinuance will be disposed of through our school pharmacy. All routine medications must be picked up no later than graduation each year.**

8. I authorize the school nurse or faculty/staff chaperone to administer prescribed or over-the-counter medications in accordance with Christ School policies, when necessary away from Wellness Center, including for sports, field trips, or after hours from AOD or houseparent.

9. I will refer to and comply with all other policies and procedures found in the Christ School Handbook related to Wellness Center Policies and Procedures.

10. I have received, read, and understand that Christ School Wellness Center has the right to change its Medication Policies and Procedures, at any time and provide notice to parents when applicable.

Parent(s)/Legal Guardian(s) name (please print): _____

Parent(s)/Legal Guardian(s) signature: _____ Date: _____

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Student Name: _____ DOB: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my son's protected health information. I understand that this information can and will be used to:
    - Conduct, plan and direct my son's treatment and follow-up among the multiple healthcare providers, Christ School officials, Wellness Team members and designated school pharmacy (upon occasion a faculty member, coach, or houseparent may need to be informed about a student's medication or condition) who may be involved in his treatment directly and indirectly.
    - Conduct related open communication (discussion of my son's medication and treatment regimen with the Wellness Team Members and/or counselor) when necessary for compliance/treatment issues. On occasion, an advisor, coach, and houseparent may need notification for continuation of care being provided.
    - Conduct normal healthcare operations such as treatment, assessment and physician referrals/exams. Diligent attempts will be made to first contact parent/guardian for approval of appointments. However, it is not necessary to wait for parent/guardian or emergency contact approval in case of emergency or delayed response from responsible parties.
- Wellness Center Staff may leave important information that relates to my son on home/cellular and or personal answering machine.

May provide health information to the following: (please list parent/guardian(s), relationship, and phone contact):

1. _____

2. _____

3. _____

I have received, read and understand your Notice of Privacy Practices. I understand Christ School Wellness Center has the right to change policies and procedures at their discretion and will notify parents/guardian of these changes.

Parent(s)/Legal Guardian(s) name (please print): _____

Parent(s)/Legal Guardian(s) signature: _____ Date: _____

CHRIST SCHOOL

AN EPISCOPAL SCHOOL FOR BOYS

Over the Counter/ Stock Medications

Parents, please initial each over-the-counter (OTC) medication your student may take at school and sign below.

_____ **Acetaminophen 325-500mg** (Tylenol) – Take 1-2 caplets every 4-6 hours as needed for pain or fever (weight adjusted)

_____ **Ibuprofen 200mg** (Advil/Motrin) **–** Take 2 tablets every 4-6 hours while symptoms persist for pain or fever (not exceed 6 tablets in 24 hours)

_____ **Diphenhydramine 25mg** (Benadryl) **–** Take 1-2 capsules every 4-6 hours as needed for allergic reaction or symptoms related to hay fever or other respiratory allergies

_____ **Loratadine 10mg** (Claritin) **–** Take 1 tablet every 24 hours as needed for relief of allergy or upper respiratory symptoms

_____ **Phenylephrine HCL 10mg** (decongestant)**–** Take 1 tablet every 4-6 hours for the relief of sinus congestion and pressure

_____ **Guaifenesin 200 mg**– Take 1-2 tablets every 4 hours for relief of cough or congestion; do not exceed 6 doses in a 24-hour period

_____ **Tussin DM** (Dextromethorphan 10mg, Guaifenesin 100mg) – Take 1-2 teaspoons every 4 hours for relief of cough when suppressant is needed; do not exceed 4 doses in a 24-hour period

_____ **Loperamide 2mg** (Imodium) – Take 2 capsules initial dose and 1 capsule after every loose stool (not to exceed 12mg in 24 hours)

_____ **Maalox/Mylanta –** Take 2-4 teaspoons 2 times a day as needed for GI upset, acid reflux, indigestion

_____ **Tums 500 or 750 mg tabs** (Calcium Carbonate) **–** Chew 2 tablets as needed for acid indigestion, heartburn

_____ **Ranitadine 75mg** (Zantac) – Take 1 tablet, 30 minutes before meal twice daily for persistent indigestion or reflux symptoms.

Parent signature_____**Date**_____