

Students Name: \_\_\_\_\_ Goes by: \_\_\_\_\_  
First Middle Last

Gender: \_\_\_\_\_(M) \_\_\_\_\_(F) Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Grade: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address (if different than student): \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell/Pgr: \_\_\_\_\_

Stepmother's Name: \_\_\_\_\_ Work Number: \_\_\_\_\_

Mothers Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address (if different than student): \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell/Pgr: \_\_\_\_\_

Stepfathers Name: \_\_\_\_\_ Work Number: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

(If different from parents)

E-mail: \_\_\_\_\_ Cell/Pgr: \_\_\_\_\_

**PERSONS TO CALL IN AN EMERGENCY OTHER THAN PARENT (MUST BE LOCAL AND ABLE TO PICK UP CHILD)**

Name	Relation to Student	Hm. PH.	Wk. PH.	Cl. PH.
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Name	Relation to Student	Hm. PH.	Wk. PH.	Cl. PH.
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Local Physician: \_\_\_\_\_  
Name Address Office Phone

Preferred Hospital in Case of Emergency: \_\_\_\_\_

**RELEASE FOR ADMINISTRATION OF TYLENOL, COUGH DROPS, TOPICAL OINTMENTS AND TUMS**

I give my permission for my child, \_\_\_\_\_ to receive the following non-prescription medications, according to the package directions, as needed for relevant symptoms they may experience while at school.

(Please check)

Acetaminophen (Tylenol) \_\_\_ Ibuprofen \_\_\_ Tums \_\_\_ Cough Drops \_\_\_  
 Topical Ointments (Benedryl Gel, Triple Antibiotic ointment, Caladryl) \_\_\_\_\_

Medication will be administered from the Clinic at Charlottesville Catholic School.

(If you elect not to sign this release, your child will not receive any of these medications from CCS Clinic personnel.)

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**(Please complete both sides)**

Medical Information: Student's Height: \_\_\_\_\_ Student's Weight: \_\_\_\_\_

Asthma: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Triggers: \_\_\_\_\_

Treatment: \_\_\_\_\_

Allergies: (Drugs, Foods, Other) Please List: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Does student take any medications? Please List: \_\_\_\_\_

**MEDICAL TREATMENT CONSENT**

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give permission for (1) the administration of any treatment deemed necessary by above named doctor or in the event the designated preferred practitioner is not available by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery. Necessary permissions are obtained prior to the performance of such surgery.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_