

Students Name: _____ Nickname: _____
First Middle Last

Father's Name: _____ Work Phone: _____

Home Phone: _____ Cell/Pgr: _____

Stepmother's Name: _____ Work Number: _____

Mothers Name: _____ Work Phone: _____

Home Phone: _____ Cell/Pgr: _____

Stepfathers Name: _____ Work Number: _____

Guardian's Name: _____ Work Phone: _____

(If different from parents)

Home Phone: _____ Cell/Pgr: _____

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

Please indicate the first person to contact in case of illness. Be sure that all phone numbers are accurate and updated as needed. Thank you

Name	Relation to Student	Hm. PH.	Wk. PH.	Cl. PH.

Name	Relation to Student	Hm. PH.	Wk. PH.	Cl. PH.

Local Physician: _____
Name Office Phone Preferred Hospital in an Emergency

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.

Signature of Parent/Guardian: _____ Date: _____

Medical Information:

Asthma: Yes _____ No _____ If Yes, Triggers: _____

Other Medical Conditions: _____

Does student take any medications? Please List: _____

Allergies: (Drugs, Foods, Other) Please List: _____

RELEASE FOR ADMINISTRATION OF IBUPROFEN, ACETAMINOPHEN OR TUMS

I give my permission for my Child, to receive the following non-prescription medications from the Nursing Clinic at Charlottesville Catholic School, according to the package directions, as needed for relevant symptoms they may experience while at school. (If you elect not to sign this release, your child will not receive any of these medications from CCS Clinic personnel.)

(Please check): Acetaminophen (Tylenol) ___ Ibuprofen ___ Tums ___

Signature of Parent/Guardian: _____ Date: _____