SCHOOL DISTRICT OF ALMA

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School Medication/Procedure Form

STUDENT INFORMATION:

Student's Name	Date of Birth	School	School Year/Effective Dates

Medication/Procedure	Dosage	Time/Frequency	Student's Practitioner

Reason for Medication/Procedure

Note: For prescription medication: ***Signed*** **Parent Consent** and ***Signed*** **Practitioner's Order** required.
For non-prescription medication: ***Signed*** **Parent Consent** required.

PARENT CONSENT: Complete for **EACH MEDICATION/PROCEDURE** at school. (Please review your school's handbook for specific information regarding the medication policy.)

I request that this medication/procedure be administered at school.

Medication will be supplied in its original, properly, labeled container.

This order is in effect for this school year unless otherwise indicated.

I will notify the school in writing for any changes and obtain a new practitioner's order.

I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication or the condition for which it is prescribed.

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

Date	**Parent/Guardian Signature**	**Telephone #**

PRACTITIONER'S ORDER: Complete for EACH PRESCRIPTION MEDICATION/PROCEDURE at school. The above medication/procedure is to be administered during the school day in accordance with the above instructions.
Please contact me if the following symptoms occur:_____

Additional information: _____

For Asthma inhaler—Student may carry inhaler in school	**Yes**	**No**
For Epinephrine Auto Injectors — Student may carry injector in school	**Yes**	**No**

Date	**Practitioner's Signature**	**Telephone #**

Student (Last Name Only)

SCHOOL DISTRICT OF ALMA

EMERGENCY FORM

Annual Registration / Medical Update (For all Pre-K - 12 Students)

Please fill out the information and authorization below and return to school immediately.

Address _____ Home Phone # _____

Mom Cell Phone # _____

Dad Cell Phone# _____

E-Mail Address *(Optional)* _____

Student resides with: _____ Mother & Father _____ Mother only _____ Father only
_____ Mother & Stepfather _____ Father & Stepmother _____ Guardian

Mother's Name _____ Occupation _____

Mother's Employer _____ Phone _____

Father's Name _____ Occupation _____

Father's Employer _____ Phone _____

We ***must*** have the names and phone numbers of ***2 local people*** who could be reached during school hours for assistance or directives if the school is unable to reach parents:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Family Doctor/Clinic _____ Phone _____

Family Dentist _____ Phone _____

Please provide the name of each student in your family:

Name of Child	Grade	List all health concerns, conditions, exams, allergies, & medications taken routinely *(If taken at school, contact the school office or school nurse for medication form)*

List any immunizations received since last school year. Type & date given _____

Do you give permission for your child to have Tylenol at school at discretion of the school health officer? Yes ___ No ___

I give the School District of Alma the authority to secure professional medical services when parent or alternate person cannot be reached or when injury is of such a nature that immediate attention is necessary.

Parent Signature _____ ***Date*** _____

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