St. Michael – Vacation Bible School – Summer 2019
Medical Form

Student: _____
Last Name First Name

Date of Birth: _____ Grade: _____

Mother's Cell: _____ Mother's Home: _____

Father's Cell: _____ Father's Home: _____

Please list any special needs or conditions your child has that the nurse should know about:

_____

_____

Current Daily Medications: _____

Allergies: _____

Height: _____ Weight: _____

This student may be given the following over the counter medications **PROVIDED BY THE PARENTS**:

Please check: Advil ☐ Benadryl ☐ Midol ☐ Sudafed ☐ Tums ☐ Tylenol ☐

I certify that the above-named camper is medically cleared to participate in the St. Michael Vacation Bible School 2019 program.

_____ _____
Parent's Signature Cell Phone

_____ _____
Date Date

St. Michael – Vacation Bible School – Summer 2019
Allergy Emergency Health Care Plan

Student: _____ DOB: _____
Last Name First Name

Allergy: _____

Asthmatic Yes* ☐ No ☐
(*High risk for severe reaction)

SIGNS OF AN ALLERGIC REACTION:

MOUTH	Itching and swelling of the lips, tongue, or mouth
THROAT	Itching, sense of tightness in the throat, hoarseness, hacking cough
SKIN	Hives, itchy rash or swelling of the face or extremities
GUT	Nausea, vomiting, cramps, or diarrhea
LUNG	Shortness of breath, coughing, wheezing
HEART	Thready pulse, passing out

FOR MINOR REACTION (localized hives, redness, itching)

Give: _____
Medication/dose/route

Then call: Mother: _____ Father: _____

FOR MAJOR REACTION (generalized hives, oral swelling, difficulty breathing)

Give: _____ IMMEDIATELY!

CALL 911 – Ask for advanced life support, then call:

Mother: _____

Father: _____

Doctor: _____

Emergency Contact: _____

Parent's Signature_____ Date_____

PRESCRIPTION MEDICATION PERMISSION FORM

All prescription medications must be sent to the clinic in their original container with the current prescription intact including the name of the prescribing physician. This completed form with the parent's signature must be on file in the clinic in order for the Nurse/Clinic personnel to administer stated medication. ***One form is to be completed for each medication prescribed***.

Please print

Date: _____

Student: _____ DOB: _____

Medication: _____

Reason it is given: _____

Form of medication to be given:

Pill ☐ Capsule ☐ Liquid ☐ Inhalation ☐

Other (specify): _____

Dosage (amount to be given): _____

How often or at what time: _____

Date to be discontinued: _____

I agree to hold St. Michael Catholic Church harmless for the proper administration of medication provided by the parent/guardian and for adverse drug reactions or side effects. I agree to be responsible for maintaining an adequate supply of medication at the school to meet my child's needs.

Parent/Guardian Signature: _____

Home Phone: _____ Cell Phone: _____