Kingsport City Schools Medical Form

2019-2020

This form is required for ALL After School and School Related Activities

Additional forms will be needed if student has a medical diagnosis of asthma, severe allergies or seizures. For additional information, contact school nurse.

Name of Extra-Curricular School Activity:_____

Student's Name: _____
(Last) (First) (Middle)

Student's Address: _____
(Number) (Street) (City) (State) (Zip)

Student's Date of Birth: _____ Grade: _____

Father's Name: _____ E-Mail: _____

Father's Address: _____

Father's Home Phone #: _____ Work Phone #: _____ Cell #: _____

Mother's Name: _____ E-Mail: _____

Mother's Address: _____

Mother's Home Phone #: _____ Work Phone #: _____ Cell #: _____

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Student's Physician: _____ Phone #: _____

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Health Insurance Company: _____

Insurance Company Address: _____

Group #: _____ ID / Subscriber #: _____

Social Security number of Card Holder: _____-_____-_____

Type of Insurance: Private_____ Group_____
No Medical Insurance at this time_____

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PERSON TO NOTIFY IN CASE OF AN EMERGENCY AND YOU CANNOT BE REACHED
(Other Than Those Listed Above)

Name: _____ Home Address: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

HEALTH HISTORY **Student's Name: _____**

Date of Birth:_____

Drug Allergy *(List)* _____ **Food** Allergy *(List)* _____

Insect Bite Allergy ***(Life Threatening)*** _____ Latex Allergy_____ Seasonal Allergy_____

Epi-Pen required for Allergy? _____Other Medications used for Allergy_____

Asthma_____ **Inhaler required?** _____Frequency used? _____ Nebulizer **required?** _____

Other Medical Problem(s) _____

Current Medications: _____

_____ Last **Tetanus** Shot: _____

Details of Treatment / Activities to be Restricted (*Requires Physician Note*):_____

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Medications/Parental Permissions

Permission for Over-the-Counter Medications

I represent that I am the mother, father, guardian of the above child. I give my permission for KCS personnel to administer, or assist in the self administration of the parent-provided medications that I have ***initialed.***

_____

(Parent / Guardian Signature)

MEDICATION

	Tylenol		Vaseline **(Overnight Trip** Use Only**)**
	Ibuprofen		Artificial Tears
	Benadryl **(Emergency Use Only)**		Baush & Lomb Eye Wash

Permission for Prescription and All Other Over-the-Counter Medications

Before administering any prescribed or over-the-counter medication (not on the approved list above) the school nurse must have the following:

- Completed Physician Form for Administration of Medication for **each** medication (**over-the-counter & prescribed medication**). This form must be **completed** by your p**hysician.**
- Each medication must be in the original, unopened container with the original label listing the ingredients.
- The student's name must be written on the container.

Please note that students are not permitted to share any medications.

(The Physician Form for Administration of Medication can be obtained from the school nurse and is good for one school year only).

Permission for Emergency Medical Treatment

- In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic.

- Permission for Accompanying Physician: I give permission for any physician who is present at any after school and/or school related activities to provide first aid/medical treatment to my child if necessary.

_____

(Parent / Guardian Signature)

Kingsport City Schools Medical Form 2011; Revised 2012; 2013; 2014; 2015, 2016; 2017; 2018; 2019.