SCHAUMBURG CHRISTIAN SCHOOL

EMERGENCY TREATMENT RELEASE
AND
MEDICATION AUTHORIZATION
(one per student)

2010-2011

200 North Roselle Road
Schaumburg, IL 60194
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FAMILY INFORMATION		
Student's Name:	**Grade**:	**O Male O Female**
Home Telephone: ( )	**Date of Birth:**	

Father's Name: _____	**Mother's Name:** _____
Daytime Phone: ( ) _____	**Daytime Phone: ( )** _____
Cell: ( ) _____	**Cell: ( )** _____

MEDICAL INFORMATION	
Student's Physician:	**Phone**:

Medical Allergies:

Food Allergy(ies) & Severity: For a severe food allergy you must complete a *Food Allergy Action Plan*.
(Please do not list a food preference which is not medically related.)

Chronic Health Conditions (i.e. Asthma, Seizure history, etc. / **Special Care Required**:

NON-MEDICAL INFORMATION

Dietary Restrictions: (Parents are responsible for providing food substitutions for lunch, snacks, etc.)

MEDICATION AUTHORIZATION

I authorize Schaumburg Christian School to administer to my child an age-appropriate dose of the following medications:

You must INITIAL in the space next to medications you will allow.

Fever/Pain	**Cold/Cough**	**Allergies**	**Stomach Upset**
Ibuprofen (i.e. Advil)_____	Cough Drops_____	Benadryl_____	Chewable Antacid (i.e. Tums)_____
Acetaminophen (i.e. Tylenol)_____		Caladryl Lotion_____	

Note: All medications from home (RX or over-the-counter) must be delivered by a parent to the school office where a parent will complete a Medication Request form. Medication from home must be in original packaging.

LOCAL EMERGENCY CONTACTS

List two responsible adults who in the case of an emergency will assume responsibility for your child if parents cannot be reached.

Name: _____	**Name:** _____
Phone: ( ) _____	**Phone: ( )** _____

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above named minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. Necessary first aid may be given at school. This release form is being completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

_____ _____

Signature of Parent or Guardian ***Date***