Sioux Falls Christian Schools
Family Medical Information – 2011-2012

Parents: If you wish to authorize the school to give Tylenol or Ibuprofen to your child(ren) when necessary, we **must** have your signature on this form. If a student has a headache, muscle aches, etc., as a convenience, we are willing to administer the pain reliever, **provided** we have your signature on file. ***Parents of Pre-K through 5th grade students will always be called before a pain reliever is given.**

Student Name__________________________ Student Name____________________________

Student Name__________________________ Student Name____________________________

I authorize Sioux Falls Christian Schools to provide Tylenol or Ibuprofen (circle one) if needed. I release the school and staff from all liability should my student suffer any reactions to the aforementioned products.

Parent Signature______________________________________ Date ______________________________________

* *

Parents: Please complete the following sections as completely as possible. List all allergies, medical conditions, medications, corrective lenses, etc. If there are no conditions that we need to be aware of, please fill in the student's name and grade and specify "NA" in the medical information column. Be sure to sign and date the bottom of this form.*

1) If prescription drugs are to be administered at school, they must be sent to school in a labeled pharmacy bottle. They will be locked in the office and administered from the office. The authorization form on the back of this page must be completed by your doctor and will be on file with the medication in the office. It is the responsibility of the parent, not the child, to inform us of any change in condition or medication. This can be done by phone with the secretary or administrator (with written confirmation from a physician within 24 hours).

2) If your child has specific dietary needs, we must have a letter from your physician telling us which foods (i.e. milk, soy, wheat, peanuts, etc) they cannot have as part of their hot lunch. Substitutions will be made as necessary, but only with a physician's letter on file. Thank you for your cooperation.

Student Name	**Grade**	**Medical Information**
__________________________	_______	____
		____
		____
__________________________	_______	____
		____
		____
__________________________	_______	____
		____

Parent Signature **Date**

Printed Parent Name____

REQUEST AND AUTHORIZATION FOR MEDICATION/TREATMENT

Students Pre-K -5th grade ph # 334-7397 fax # 334-3026
Students 6th – 12th grade ph # 334-1422 fax # 334-6928

This request must be completed annually OR immediately if change in dosage/treatment occurs.

Student ______________________________ Birth date ______________________

Address ______________________________ Telephone ______________________

Parent(s) ______________________________

Physician ______________________________

1. Diagnosis: ____

____

2. Name of medication/treatment: ____

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3. Dosage Amount: ____

____

4. Time(s) of Administration: ____

____

5. Method of Administration: ____

____

6. Precautions and reactions to observe and report: _____________________________________

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Physician Signature ________________________________ Telephone ______________Date______

Parent Signature ___________________________________ Telephone ______________Date______

Printed Parent Name ________________________________