

List medication child takes: _____

Special dietary regimen: _____

List any health conditions or restrictions... such as ADHD, allergies, heart disease, diabetes, epilepsy, eye or ear problems, or any chronic problems:

Appropriate medication form **must** be on file with the school nurse for all prescription and over-the-counter medication.

All medications to be taken at school **must** be administered through the Health Room.

DISCRETIONARY ITEMS: The nurse or designee in her absence may administer the following items to this child as needed: (Check those we **MAY** give) Neosporin _____, Peroxide _____, Throat Lozenges _____, Anti-itch lotion or spray (Cortisone) _____, Sunscreen _____, Rubbing Alcohol _____.

Please list this child's sibling(s), age(s), and school(s):

Sibling 1: _____ Age: _____ School: _____
Sibling 2: _____ Age: _____ School: _____
Sibling 3: _____ Age: _____ School: _____
Sibling 4: _____ Age: _____ School: _____

AS A GENERAL RULE, GERSTELL ACADEMY WILL ATTEMPT TO CONTACT THE PARENTS, LEGAL GUARDIANS, ASSIGNED RESPONSIBLE RELATIVES OR NEIGHBORS FIRST. IN THE EVENT CONTACT CANNOT BE MADE, I UNDERSTAND AND HEREBY AUTHORIZE AND CONSENT TO THE HEAD OF GERSTELL ACADEMY OR HIS/HER AGENT TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR MY CHILD.

I FURTHER AGREE TO PAY AND TO HOLD GERSTELL ACADEMY HARMLESS ON ACCOUNT OF ANY MEDICAL, DENTAL, HOSPITAL, TRANSPORTATION OR OTHER RELATED CHARGES INCURRED ON BEHALF OF THE CHILD.

I GIVE PERMISSION FOR THE SCHOOL NURSE TO SHARE INFORMATION RELEVANT TO MY CHILD'S HEALTH CONDITION WITH APPROPRIATE SCHOOL PERSONNEL WHEN NEEDED TO MEET MY CHILD'S HEALTH AND SAFETY NEEDS.

THANK YOU.

Signature of Parent/Guardian

Date

Signature of Other Parent

Date