STUDENT'S LAST NAME:_____

education . . . the adventure of a lifetime

SEAFORD UNION FREE SCHOOL DISTRICT

SEAFORD HIGH SCHOOL • 1575 SEAMANS NECK ROAD • SEAFORD • NEW YORK • 11783 • (516) 592-4380 • FAX (516) 592-4301

SCOTT BERSIN
PRINCIPAL

DR. ADELE PECORA
SUPERINTENDENT OF SCHOOLS

JENNIFER BISULCA
ASSISTANT PRINCIPAL

NICOLE SCHNABEL
ASSISTANT PRINCIPAL

Medical Information & Authorization to Consent to Medical Treatment for a Minor Child

This form must be filled out by parent/guardian AND child's physician.

I,_____, am the parent/ legal guardian of
(Full Name)

_____ , a minor child in ____ grade who was born on_____
(Student's Full Name)

and whose age is _____ and resides at: _____
Street Address, Town, State & Zip Code

_____ _____
Parent's Home Phone Parent's Work Phone

in the County of Nassau.

I give permission for an adult chaperone provided by the Music Department of the Seaford Union Free School District, 1575 Seaman's Neck Road, in the County of Nassau, State of New York, to authorize emergency treatment which may be necessary for my minor child named above, while participating in this year's events, when efforts to contact me are unsuccessful or not possible. Such treatment to include, but not limited to: examinations, x-rays, laboratory tests, medical and surgical treatment, use of medication, anesthetics, cultures and admission for hospital care as may be required.

It is understood that such care will be upon the advice of a duly licensed practitioner.

Parent/Guardian Signuture_____Date_____/_____/_____

******Emergency Phone Numbers******

Name:_____ Relation:_____ Phone: (___)_____

Name:_____ Relation:_____ Phone: (___)_____

******Form will last through all 4 years of High School. Please send in updates as needed******

Medical History

Name of Child's Doctor:_____ Parent's Family Doctor:_____

Phone:(____)_____ Phone:(____)_____

Child's Allergies(including Foods):_____ Drug Allergies:_____

Medications Child is taking/ how often/Dosage:_____

Form (Pills, liquid, Inhaler, injection, etc.):_____

For What Condition:_____

Has your Child been instructed in and understands purpose and appropriate method and frequency of use?_____

Other pertinent past medical history or present medical restrictions: (explain fully)

_____

Date of last Tetanus Shot:____/____/____Does child have a physical handicap? If so, explain:_____

Should nature and amount of physical exercise be limited? If so, explain:_____

PLEASE CHECK ONE: Student (___) May (___) May NOT Swim. (if left blank, student will not be able to swim.)

Please check as necessary: (__) Glasses (__) Contact lenses (__) Braces (__)Other(specify)_____

Please check and date if child has had any of the following: (_____) Rheumatic Fever, (_____) Tuberculosis,

(_____) Asthma, (_____) Diabetes, (_____) Thyroid Disease, (_____) Emotional Disease,

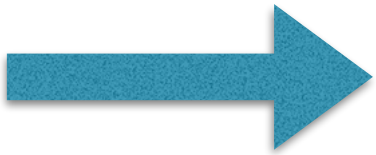
(_____) Pneumonia, (_____) Heart Disease (murmurs), (_____) Hives,hay fever allergies,

(_____) Bone/joint Disease, (_____) High or low blood pressure, (_____) Liver Disease (hepatitis),

(_____)Stomach/ bowel trouble, (_____) Kidney or urinary problems, (_____) Epilepsy, convulsions

(_____) Other (please list)_____, (_____) Other (please list)_____

Attach copy of updated health insurance card



ATTACH CARD HERE

Standard Over-the-Counter Medications (needs to be filled out by physician)

The following medications are allowed to be carried and self-administered with parent/guardian AND physicians approval. Please select which medication will be sent with your child. You may use the blanks to fill in any over the counter medications that are not listed. Add additional medications as needed.

Key: PRN (as needed) PO (taken by mouth) Topical (applied to skin) Q (every)

Drug Name	Route	Dosage	Schedule and Indications	Health Care Provider Permission	Comments
Motrin/Ibuprofen	PO (chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Tylenol/ Acetaminophen	PO (chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Robitusin/ Robitusin DM	PO (liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs	YES NO	
Benadryl/ Diphenhydramine	PO/Topical (pills, liquid or spray)	Per label instruction by age/weight	PRN - Insect bites, allergies, respiratory allergies	YES NO	
Mylanta/Pepto/ Tums/Rolaids/ other antacids	PO (chewable tabs or elixir)	Per label instruction by age/weight	BID-TID PRN Upset stomach	YES NO	
Dramamine	PO (chewable tabs)	Per label instruction by age/weight	Q 6-8 hrs Motion Sickness	YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Licensed Physician's Signature_____License #_____

Address_____Phone (_____)_____-_____

Date of Form Completion_____/_____/_____By_____

Initial if completed by nurse or physician's assistant

___*Check here to decline, no doctor's signature needed. Parent Signature*_____