



## 2022-23 Medical/Release Information

Office Use
Class: _____
Medication Alert: _____
IHCP Completion Date: _____

Student's Name: \_\_\_\_\_

Parents' Names: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

### Field Trip Permission

I hereby give permission for my child to be taken on supervised field trips throughout the school year, by foot or by car. I understand that I will receive advance notice of all field trips.

\_\_\_\_\_  
Parent Signature

### Medical Release

If serious illness or accident occurs at school or other locations and neither parents nor person listed below can be reached, I/We give permission to the teachers and staff of First Presbyterian Preschool to secure medical care from our physician \_\_\_\_\_ phone \_\_\_\_\_ or his/her associates, or from the most immediately available licensed health care professional. I/We accept full responsibility for any financial indebtedness related to transporting and treating my child at a hospital or medical clinic.

\_\_\_\_\_  
Parent Signature

### Other Authorized Pick-up Persons (Other than Parents. Please list at least 1 alternate pick-up person)

Name:	Contact Phone #1	Contact Phone #2	Relationship
1.			
2.			
3.			
4.			
5.			

### Emergency Contacts - Contact in this priority (Other than Parents- Parents will always be contacted first!)

Name:	Contact Phone #1	Contact Phone #2	Relationship
1.			
2.			

### OUT-OF-STATE EMERGENCY CONTACT

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Does your child attend daycare or another school? Yes  No  If Yes: Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Please list the days of the week and times: \_\_\_\_\_

Please complete the Medical Information on the other side. Thank you.

# Medical Information

## Immunizations

A completed Immunization form or signed Certificate of Exemption must be on file in school office before your child can attend class. All immunizations must be on the Washington State Department of Health Certificate of Immunization form. These forms are available in the school office.

## Medical History

Please check any of the following that may affect school performance or require special management/medication at school. If you check an item, please indicate whether medication for that condition is required at school, and if it is required, please list the medications.

- |  |   |
|--|---|
| <input type="checkbox"/> Medication allergies (Please List Medications) _____<br>_____ | <input type="checkbox"/> Emotional/Behavioral Issues: _____<br>Has the child seen a physician for this issue? _____ |
| <input type="checkbox"/> Allergies (requiring medication) _____                        | <input type="checkbox"/> Headaches/Stomachaches _____   |
| <input type="checkbox"/> Asthma (requiring medication) _____                           | <input type="checkbox"/> ADD/ADHD _____   |
| <input type="checkbox"/> Physical Disability _____                                     | <input type="checkbox"/> Convulsions/Seizures _____   |
| <input type="checkbox"/> Medication regularly taken <b>at home</b> _____               | <input type="checkbox"/> Epilepsy _____   |
| <input type="checkbox"/> Blood disease _____   | <input type="checkbox"/> Kidney disease _____   |
| <input type="checkbox"/> Food Intolerance _____  | <input type="checkbox"/> Hearing Loss _____   |
| <input type="checkbox"/> Contact lenses _____  | <input type="checkbox"/> Diabetes _____   |
| <input type="checkbox"/> Eyeglasses _____  | <input type="checkbox"/> Nosebleeds _____   |
| <input type="checkbox"/> Heart disease _____   | <input type="checkbox"/> Chronic Diseases _____   |
| <input type="checkbox"/> Rheumatic Fever _____   | <input type="checkbox"/> Other _____  |

If you checked any of the above conditions, and medication is required at school for that condition, please refer to the checklist below to learn what we will need before your child can attend class.

## Information Needed for Students with Allergies

Allergy Reaction Information:

My child's allergic response is triggered by:  Ingestion     Touch     Inhalation     Other (Specify below)

Other allergic response trigger:

\_\_\_\_\_

Has your student ever experienced an episode of anaphylaxis requiring an EpiPen or hospitalization?  No     Yes

If yes, please list each incident including date: \_\_\_\_\_

\_\_\_\_\_

Please describe how the allergic response manifests itself in your student: \_\_\_\_\_

\_\_\_\_\_

## Checklist for medication to be administered at school

The following items must be received prior to the first day of school.

- All medication must be submitted with a completed Health Care Provider's Order for Medication at School form.
- For students keeping medication at school, ***an Individual Health Plan must be completed with your child's teacher.***
- All prescription medication must have the pharmacy label with student's name attached to the medication.
- All over the counter medication must be in its original packaging.
- Please check expiration dates before bringing in medication. Medication must not expire during the school year.