Rowanty Technical Center
Student Medication Contact Form

Please print

Student Name _____ **DOB (mm/dd/yy)** _____

1. **In case of emergency, do you give permission for your child to be transported by rescue squad to Southside Regional Medical Center? ☐ Yes ☐ No**

If not, please provide instructions: _____

2. **DO YOU GIVE PERMISSION FOR YOUR CHILD TO BE TREATED IF YOU CANNOT BE REACHED? ☐ Yes ☐ No**

Please ✓ all that apply and give detailed explanation for each condition.

_____ Heart condition _____ Spinal _____ Hearing

_____ Convulsions _____ Speech _____ Panic/ Anxiety Attacks

_____ Fainting Spells _____ Urinary

_____ Migraines _____ Digestion

_____ Vision problems _____ W**ears** eyeglasses _____ **Wears** contact lenses

_____ Diabetes/blood sugar problems: _____ Health Plan on file w/Home School Nurse

_____ Respiratory (including asthma): _____ Health Plan on file w/Home School Nurse

If yes on any of the above items, please explain: _____

_____

_____ Allergies: ☐ Food ☐ Environmental ☐ Medications Please list: _____

_____

_____ Major Surgeries: _____

_____ Other: _____

3. **Is your child currently taking any form of prescription medication? ☐ Yes ☐ No** If yes, please write the name below (attach additional page if needed):

Current Medication Being Taken: _____

Reason for Medication: _____

Description of any side effects which may need to be observed and reported to you: _____

Please attach any additional forms if needed.

If it is necessary for this medication to be administered during the school day, including students who carry inhalers, you must contact the school and request that a **Medication Administration Form** be emailed to you. This form must be completed and signed by your child's physician/parent prior to the administration of any medication by school staff.

Parent/Guardian signature _____ **Date** _____