

The information on this page, completed by a parent, is to be used by Mater Dei School to assist in obtaining medical care in extreme circumstances; for contacting parents in the event of a medical emergency and for obtaining parental consent to participate in school events.

_____/_____/_____
 LAST NAME FIRST NAME M.I. DATE OF BIRTH GRADE 2011-12

 HOUSE # STREET CITY STATE ZIP

EMERGENCY CONTACT PHONE NUMBERS

Physician: _____ Phone #: _____

Mother:	(H)	(W)	(C)
Father:	(H)	(W)	(C)
Additional Contact:	(H)	(W)	(C)

PERMISSION FOR EMERGENCY TREATMENT: In the event a parent cannot be reached, I authorize the administration of Mater Dei School to obtain emergency medical treatment for the health of my son. I will not hold the school responsible for the emergency care and/or transportation for said student.

 Parent Signature Parent Name (please print) _____ / ____ / ____
 Date

BRIEF HEALTH HISTORY

<i>Description of Allergy/Illness/Medical Condition</i>	<i>List Reaction & Treatment</i>
<input type="checkbox"/> Severe Allergy to _____:	
<input type="checkbox"/> Medication allergy/allergies:	
<input type="checkbox"/> Other Allergy _____:	
<input type="checkbox"/> Asthma/Reactive Airway:	
<input type="checkbox"/> Diabetes:	
<input type="checkbox"/> Other medical concerns:	
<input type="checkbox"/> EpiPen: My son requires an EpiPen at school for: _____. <i>(Please supply epipen to the main office, labeled with your son's name on the first day of school)</i>	
<input type="checkbox"/> Inhaler: My son requires an inhaler at school for: _____. <i>(Please supply inhaler to the main office labeled with your son's name on the first day of school)</i>	

If there is not enough room provided, please attach additional sheet(s).

OVER THE COUNTER MEDICATIONS: Although Mater Dei's policy is to **NOT ADMINISTER** any routine or prescription medications, I give my permission (in the event of **extreme circumstances**) to the Headmaster or his designee to dispense age/weight appropriate dose of Tylenol, Acetaminophen, Ibuprofen, for pain or fever; Benadryl for allergic reactions; Tums, Pepto Bismol for stomach upset; Cough Drops, Lozenges for congestion, sore throat, cough; Neosporin for lacerations, scratches, Hydrocortisone .5/1% topical cream or Caladryl lotion for itchy rash, insect bites.

My son _____, MAY receive the over the counter medications listed above in the event of extreme circumstances.

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

PARENTAL PERMISSION FOR OFF-CAMPUS ACTIVITIES: By signing below, I grant permission for my son to participate in and to be transported to and from Mater Dei School off-campus activities. These activities include, but are not limited to: field trips, outdoor week and volunteer experiences.

 Parent Signature Parent Name (please print) _____ / ____ / ____
 Date