MEDICATION INFORMATION

Permission to Administer Medications

I, (parent/guardian name) _____ give permission to authorized personnel at Via Vita Veritas Summer School to administer emergency care and/or medications to my child: (child's name) _____while at our summer school.

I give permission for authorized staff to administer the following medications to my child per school Physician Standing Orders, as well as the protocol for medication administration. Please indicate your permission by placing an "X" next to approved medication.

____acetaminophen (Tylenol) ___Ibuprofen (Motrin) ___ Robitussin

___Topical skin application of Calamine Lotion ___Diphenhydramine (Benadryl)

___ Hydrocortisone 1% cream ___Pepto Bismol ___NIX treatment (for head lice)

Please complete below for prescription medications your child needs to receive during summer school:

Medicine Name	Dosage	Times to Dispense

Please list any allergies your child has (medication, bees, foods, etc.) and the type of reaction he or she may experience (anaphylactic, rash, digestive issues, etc.) or any other serious medical issues (diabetes, seizure disorders, etc.) that the nurse should be aware of immediately upon your child's arrival to Summer school.

Parent Signature:_____ **Date:_____**

*****ALL <u>PRESCRIPTION AND OVER THE COUNTER MEDICATIONS</u> MUST COME TO VVVSS IN ORIGINAL BOTTLE OR CONTAINER OR THEY WILL NOT BE DISPENSED*****

Via Vita Veritas Summer School

EMERGENCY INFOMATION

CONTACT INFORMATION (In order to be contacted)

Student's Name	
Parent/Guardian Name 1	
Home Address	
Primary/Cell Phone	
Secondary/Work Phone	
Parent/Guardian Name 2	
Home Address	
Primary/Cell Phone	
Secondary/Work Phone	

DESIGNATED EMERGENCY CONTACTS OTHER THAN GUARDIAN LISTED ABOVE

Name	
Relationship	
Phone	

EMERGENCY AUTHORIZATION

I authorize staff in the VVVSS/registered nurse of NEIA who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility, and to secure necessary medical treatment for my child. I understand that all medical costs would remain my responsibility.

Parent Signature:_____ **Date:**_____

Insurance/Medical Information

Insurance Carrier:	
Policy Number:	
Child's Primary Care Doctor's name	
Child's Primary Care Doctor's phone	
Child's Primary Care Doctor's address	