

***Christ the King Catholic School***

Forms:

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Medication Administration Release Form - Page 4

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# CTK School - Emergency Information Form

Last Name	Father	Mother
Student	Student	Student
Student	Student	Student

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Ph# \_\_\_\_\_

Mom's Home \_\_\_\_\_ Dad's Home \_\_\_\_\_  
 E-mail address: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**\*Please put an asterisk next to the number you would like us to call first.**

Mother's Place of Employment: \_\_\_\_\_ Father's Place of Employment: \_\_\_\_\_

Name of Business	Phone# _____	Name of Business	Phone# _____
	Pager# _____		Pager# _____
	Mobile# _____		Mobile# _____
E-mail address _____		E-mail address _____	

Mom's at work

Dad's at work

**\*Please put an asterisk next to the e-mail address that you want the most info sent.**

**List a neighbor or relative who will assume care of your child if you cannot be reached in an emergency:**

	Name/Relationship/Phone
	Name/Relationship/Phone

Student lives with:  Both Parents  Father Only  Mother Only  Father/Stepmother  Mother/Stepfather  Foster Parents  
 Legal Guardian  Other: \_\_\_\_\_

In case of serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician listed below and follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary including transportation of the child.

Signature/Parent-Guardian \_\_\_\_\_ Date \_\_\_\_\_

Allergies \_\_\_\_\_

Other Conditions \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Physician \_\_\_\_\_

Address \_\_\_\_\_

Physician's Office Phone \_\_\_\_\_

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Name

I will pick up my children every day before 3:00 p.m.     My children are in a carpool w/ \_\_\_\_\_  
 \_\_\_\_\_ will pick up my children on \_\_\_\_\_ and will be picked up every day **before 3:00 p.m.**  
 Mon    Tue    Wed    Thu    Fri

Has my permission to walk home  
Comments: \_\_\_\_\_

Has my permission to ride a bicycle to and from school  
Comments: \_\_\_\_\_

My child(ren) ride the \_\_\_\_\_ van/bus after school.  
Van/Bus - Phone # \_\_\_\_\_  
 Mon    Tue    Wed    Thu    Fri

My child(ren) **are** registered in  
CHRIST THE KING AFTER SCHOOL CARE:  
 Mon    Tue    Wed    Thu    Fri

My child(ren) **are not** registered in CHRIST THE KING  
AFTER SCHOOL CARE, but if they haven't been picked up  
by 3:00 p.m., you have my permission to send them to  
CHRIST THE KING AFTER SCHOOL CARE and I will pay  
the current per-child drop-in rate.

**ALL CHILDREN NOT PICKED UP BY 3:00 P.M. ARE SENT TO CHRIST THE KING AFTER SCHOOL CARE AND  
THE CURRENT DROP-IN RATE IS APPLIED.**

# MEDICATION ADMINISTRATION RELEASE FORM

Date \_\_\_\_\_

I request that you give medication to my child during the school day in accordance with Board policy printed below. I will not hold the school staff responsible for any undesired reaction which may occur from the medication.

I agree to pay for ambulance service if used to transport my child from school to the doctor or hospital should he/she have a reaction to the medication.

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

Student's Name \_\_\_\_\_ Class \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage: \_\_\_\_\_ mg, tsp., etc.  
# of tabs \_\_\_\_\_

Reason for Prescription \_\_\_\_\_

Choose time to be given: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. [ ] before lunch [ ] after lunch  
[ ] as needed

In case of emergency call \_\_\_\_\_ Phone \_\_\_\_\_

Hospital to be called \_\_\_\_\_ Phone \_\_\_\_\_

Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_

Clinic Name \_\_\_\_\_

## MEDICATION PROCEDURE

### *GUIDELINES*

1. The medication must be in the current, original container with your child's name on the prescription.
2. No medication to be given three (3) times daily or less will be administered at school.
3. The consent form must be signed before any medication will be given at school.

**HANDWRITTEN NOTES ARE NOT ACCEPTABLE.**

NEW STUDENT

CHANGE OF ADDRESS

NEW PHONE

# \_\_\_\_\_

Effective Date \_\_\_\_\_

\_\_\_\_\_  
PARENT(S) NAME

\_\_\_\_\_  
NEW ADDRESS

\_\_\_\_\_  
CITY AR ZIP

\_\_\_\_\_  
STUDENT Grade

\_\_\_\_\_  
STUDENT Grade

\_\_\_\_\_  
STUDENT Grade

DIANE

CYNTHIA

CHURCH OFFICE

SMS

School Directory

Student Folder

HOMEROOM

Revised 9/09

NEW STUDENT

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NEW PHONE

# \_\_\_\_\_

Effective Date \_\_\_\_\_

\_\_\_\_\_  
PARENT(S) NAME

\_\_\_\_\_  
NEW ADDRESS

\_\_\_\_\_  
CITY AR ZIP

\_\_\_\_\_  
STUDENT Grade

\_\_\_\_\_  
STUDENT Grade

\_\_\_\_\_  
STUDENT Grade

DIANE

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**Child's development needs:**

Physical or emotional problems the child might have: \_\_\_\_\_

Child's special food needs: Formula \_\_\_\_\_ Diabetic diet \_\_\_\_\_ Allergies \_\_\_\_\_

Special problems: Medications \_\_\_\_\_

Allergies \_\_\_\_\_ Temper Tantrums \_\_\_\_\_ Diabetes \_\_\_\_\_ Frequent colds \_\_\_\_\_ Biting \_\_\_\_\_

Sun Sensitivity \_\_\_\_\_ Seizures \_\_\_\_\_ Fainting Spells \_\_\_\_\_ Bed wetting \_\_\_\_\_ Other \_\_\_\_\_

Requires help in: Dressing \_\_\_\_\_ Undressing \_\_\_\_\_ Toileting \_\_\_\_\_ Eating \_\_\_\_\_ Washing hands \_\_\_\_\_

Child is toilet trained Yes \_\_\_\_\_ No \_\_\_\_\_ Words used in toileting \_\_\_\_\_

Favorite: Games \_\_\_\_\_ Toys \_\_\_\_\_ Foods \_\_\_\_\_

Siblings? Yes \_\_\_\_\_ No \_\_\_\_\_ Name(s) of siblings: \_\_\_\_\_

Type of child care used before: \_\_\_\_\_

Other useful information \_\_\_\_\_

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