Marin Horizon School

Health Information & Authorization
¡Hola Panamá! Program

GENERAL INFORMATION			
Student Name ("Student"):			Date of Birth:
Gender:			
Name of Parent/Guardian 1:			
Home Address:			
Parent 1 Home Phone:	Parent 1 Work Phone:		Parent 1 Cell Phone:
Employer:			
Name of Parent/Guardian 2:			
Home Address:			
Parent 2 Home Phone:	Parent 2 Work Phone:		Parent 2 Cell Phone:
Employer:			
Friend or Relative to call in Emergency (other than parents) Name:		Phone:	
		Relationship to Student:	

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HEALTH INFORMATION NEEDED FOR STUDENT'S PROTECTION AND CARE:	
Please describe any medical conditions (physical and/or mental) that may interfere with Student's ability to participate in the Program or any of its activities.	
Name of Student's physician:	
Address:	
Phone:	
Date of most recent tetanus shot:	
To help us supervise Student, the following information is necessary:	
Does Student sleepwalk? □ Yes □ No	
Does Student have any serious allergies? □ Yes □ No	
If yes, please describe any allergies (e.g., hayfever, pollen, food):	

AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER ("OTC") MEDICATION PROVIDED BY THE SCHOOL:
The School makes available certain OTC medications, listed below, for the relief of minor discomfort. Parents must select which OTC medications they authorize the School to administer to Student. Please note that, if a parent does not authorize the distribution of a School-provided OTC medication to Student, the School will not administer the medication(s) to Student under any circumstances. Please check either the "Yes" or "No" box:
5. Do you give authorization for any chaperone or adult accompanying Student to administer **Acetaminophen** (Tylenol or generic brand) as needed for fever or pain relief? ☐ Yes ☐ No

6. Do you give authorization for any chaperone or adult accompanying Student to administer **Diphenhydramine** (Benadryl or generic brand) as needed for allergy relief?

☐ Yes ☐ No

AUTHORIZATION FOR SELF-ADMINISTATION OF PRESCRIPTION OR OTC MEDICATIONS BROUGHT BY STUDENT

All medication should be clearly labeled with Student's name, name of medication, and dosage instructions. Please remember that all medications must be in their original containers; prescription drugs must be in original containers with the pharmacy label. ***The School does not permit students to bring prescription or OTC medication in baggies, envelopes or containers other than the original container for the medication.*** *Student may not self-carry or self-administer OTC medications unless authorized in this form by Student's parents/guardians. In addition, Student may not self-carry or self-administer prescription medications unless authorized in this form by Student's parents/guardians and his/her medical provider. Parents may also elect to have adult chaperones hold the medication for Student to be administered by Student by himself/herself according to the dosing and time schedule indicated on this form.*

Is Student bringing medication (prescription or over the counter)?	☐ Yes ☐ No

Consent for Self-Administration of OTC Medication by Student during ¡Hola Panamá! Program

Name of Medication	Dosage	Approximate Time to Administer	Duration	Reason	Self-Carry?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If necessary, continue on separate sheet and attach to this form.

PARENT SIGNATURE REQUIRED:

I, parent/guardian of Student, authorize the School and its employees and agents to hold on behalf of Student the medication(s) listed above according to the directions listed above. I agree that it is my responsibility to provide the School with unexpired, properly labeled doses/supplies for Student. I acknowledge and agree that I will immediately notify the School by phone and in writing of any changes in the Student's medication needs. I authorize the School to consult with the Student's physician/medical provider regarding any questions related to the Student's medication/supplies. I acknowledge that both I, and the Student, must adhere to all School procedures and rules concerning the handling and administration of such medication(s)/supplies. I understand that the School will not administer any medications brought by Student.

_____

Parent/Guardian 1 Signature Parent/Guardian 1 Printed Name Date

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Parent/Guardian 2 Signature Parent/Guardian 2 Printed Name Date

Consent for Self-Administration of Prescription Medication by Student during ¡Hola Panamá! Program

Name of Medication	Dosage	Approximate Time to Administer	Duration	Reason	Self-Carry?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If necessary, continue on separate sheet and attach to this form.

PHYSICIAN'S SIGNATURE REQUIRED:

I affirm that I am the above-named Student's physician or medical provider and that I have prescribed the above-listed medication, to be self-administered at the dosage, times and duration listed above. I further affirm that I have provided Student with proper instruction in the use and self-administration of the medication/supplies.

Physician's Signature Physician's Printed Name Date

Physician's Tel. Number Physician's Fax Number

PARENT/GUARDIAN SIGNATURE REQUIRED:

I, the parent/guardian of Student, give my consent to the School and its employees or agents to hold on behalf of Student the prescription medication(s) listed above for the Student to self-administer consistent with the instructions set out in the chart above. I understand that it is my responsibility to furnish this medication and that any prescription medication must be brought on the Program in a container appropriately labeled by the pharmacy stating the name of Student, name of the medication, dosage and time schedule. I agree that it is my responsibility to ensure that Student is provided with unexpired, properly labeled doses/supplies and that Student has been trained to administer/use the medication(s)/supplies without supervision by Program chaperones. In the event that Student is unable to administer the medication(s)/supplies without supervision by Program chaperones, I agree that Student will be assisted by Program chaperones. I acknowledge and agree that I will immediately notify the School by phone and in writing of any changes in Student's medication needs. I authorize School to consult with Student's physician/medical provider regarding any questions related to Student's medication/supplies. I acknowledge that Student must not share the medication(s)/supplies with others and that both I, and the Student, must adhere to all School procedures and rules concerning the handling and administration of such medication(s)/supplies.

Parent/Guardian 1 Signature Parent/Guardian 1 Printed Name Date

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Parent/Guardian 2 Signature	Parent/Guardian 2 Printed Name	Date

MEDICAL INSURANCE INFORMATION

Company Name:	
Agent:	Policy Number:
Primary Subscriber Name:	Primary Subscriber Date of Birth:

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

If Student becomes ill or incapacitated, I authorize the School, its representatives, or any adult accompanying Student on the Program to take whatever action is deemed reasonable under the circumstances in the sole judgment of the School, its agents or employees, to preserve Student's health and safety, including, without limitation, obtaining medical or dental treatment for Student at Parent's expense, administration of emergency medications, and/or transportation of Student at Parent's expense to a medical facility or to return home for medical, dental, or other reasons. I expressly authorize any adult accompanying Student on the Program to consent to the administration of medical or dental care to Student as deemed appropriate. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. I understand that, in the event of an injury to Student or Student illness, the School will make reasonable efforts to contact me, but that contact with us is not required before taking Student to a health care provider for medical or dental care. I also agree to assume any and all financial responsibility for emergency care and services to Student, including transportation services.

Parent/Guardian 1 Signature	Parent/Guardian 1 Printed Name	Date
Parent/Guardian 2 Signature	Parent/Guardian 2 Printed Name	Date

SIGNATURES

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By signing below, I certify that the above information is correct to the best of my knowledge. I agree to notify the School by phone and in writing should any of the above information change.

Parent/Guardian 1 Signature	Parent/Guardian 1 Printed Name	Date
Parent/Guardian 2 Signature	Parent/Guardian 2 Printed Name	Date

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