KidUnity

Student Medical Form

Civics in Action: Washington D.C.

March 9 - March 13, 2019

Please print clearly:

Name of Participant _____ Dates of trip: Mar 9 - Mar 13, 2019

Home phone _____

Mother's cell phone _____Father's cell phone_____

Address _____ City _____ State _____

In case of emergency, please notify: Parent(s)/Guardian(s) Name _____

Daytime phone number _____ Business phone number _____

Alternate person in case of emergency: please notify _____ at _____

Name/Phone of Family Physician _____

Family Medical Insurance Carrier _____ Child's Member # _____

Phone Number of Insurance Carrier _____

****

Participant Health Information

1. Does the participant have any physical or medical conditions or restrictions? Yes _____ No _____

If so, please describe: _____

If your child has a special medical or physical condition, your physician should understand that the participant will be away from home for seven full days. Please have your physician write a note indicating agreement that the participant is fit enough to fully participate in the program and also to include any special instructions.

2. Is your child subject to any of the following: Please circle:

Homesickness Sleepwalking Bed Wetting Car/Motion Sickness

3. Does your child have any dietary requirements or restrictions? Yes _____ No _____

If so, please describe: _____

4. Does your child have any allergies that may be of concern? Yes _____ No _____

If so, please describe the severity: _____

5. Has your child recently been ill or exposed to any communicable diseases? Yes _____ No _____

If so, please explain: _____

6. Medication

In order for your child to receive any medication during the Civics in Action: Washington DC program, an ADMINISTRATION OF MEDICATION form must be completed for each medication prescribed for the period your child will attend the program.

If your child is under a doctor's care for an acute or chronic condition, your physician should understand that your child will be away from home for a full seven days. Any special instructions should be attached to this form.

Participant's Name _____ Dates of Trip: Mar 9 - Mar 13, 2019

Authorization and Consent for Participant Medical Treatment

1. Parent/Guardian will be notified immediately if a child becomes injured or seriously ill, and aid will be given according to the parent/guardian's wishes.

2. A child will not be released during the program to anyone other than a parent or guardian without written request by the parent or guardian.

3. I/We _____ do hereby authorize KidUnity and Carlthorp School staff as agents for the undersigned to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and/or surgeon licensed under the provisions of state law who is on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization shall remain in effect through the completion of the travel at the end of the day March 13, 2019 unless revoked sooner in writing and delivered to said agents.

Parent/Guardian Signature _____

Date _____

Child Participant's Name _____
Please Print

Participant's Name _____ Dates of Trip: Mar 9 - Mar 13, 2019

Part A: KidUnity Supplied Non-Prescription Medication

I, the undersigned parent or legal guardian of _____
(Child's Name)
authorize any KidUnity or Carlthorp chaperone/teacher on the trip to administer over the counter medications to said minor as instructed on the package or as directed in writing by me.

_____
(Parent or Guardian Signature)

Fill out for any of the following non-prescription medications you give permission for your child to take.

Child's Age _____ Child's Weight _____

MEDICATIONS PROVIDED BY THE SCHOOL

TYLENOL JUNIOR Reason for Administration of Medication (headache, allergies, etc.)

_____

Dosage: As directed on label YES _____ NO _____(explain)_____

Comments _____

Parent/Guardian signature _____

CHILDREN'S MOTRIN Reason for Administration of Medication (headache, allergies, etc.)

_____

Dosage: As directed on label YES _____ NO _____(explain)_____

Comments _____

Parent/Guardian signature _____

CHILDREN'S PEPTO BISMOL Reason for Administration of Medication (headache, allergies, etc.)

_____

Dosage: As directed on label YES _____ NO _____(explain)_____

Comments _____

Parent/Guardian signature _____

Name of Participant _____ Dates: Mar 9 - Mar 13, 2018

Part B: Parent Supplied Non-Prescription Medication

Fill out for any non-prescription medications you are sending with your child:

Age _____ Weight _____

For over-the-counter medications that were not listed on the previous Part A, parents will need to provide the medication and fill out this form.

a) label the container with your child's name
b) write the dosage information
c) place it in a plastic zip loc bag
d) give it to a KidUnity/Carlthorp chaperone/teacher

MEDICATION 1

Medication _____ Dosage _____

Reason for Administration of Medication (headache, allergies, etc.) _____

Schedule and Method of Administration _____

Comments _____

Parent/Guardian signature _____

MEDICATION 2

Medication _____ Dosage _____

Reason for Administration of Medication (headache, allergies, etc.) _____

Schedule and Method of Administration _____

Comments _____

Parent/Guardian signature _____

MEDICATION 3

Medication _____ Dosage _____

Reason for Administration of Medication (headache, allergies, etc.) _____

Schedule and Method of Administration _____

Comments _____

Parent/Guardian signature _____

MEDICATION 4

Medication _____ Dosage _____

Reason for Administration of Medication (headache, allergies, etc.) _____

Schedule and Method of Administration _____

Comments _____

Parent/Guardian signature _____

Participant's Name _____ Dates of Trip: Mar 9 - Mar 13, 2019

PART C: Prescription Medication

***For prescription medications only-medications to be supplied by parents**

MEDICATION 1

Diagnosis _____ **Date of Exam** _____

Medication Prescribed _____ **Dosage** _____

Schedule and Method of Administration _____

_____

Comments _____

Physician's Signature _____ **Parent/Guardian Signature**_____

MEDICATION 2

Diagnosis _____ **Date of Exam** _____

Medication Prescribed _____ **Dosage** _____

Schedule and Method of Administration _____

_____

Comments _____

Physician's Signature _____ **Parent/Guardian Signature**_____

MEDICATION 3

Diagnosis _____ **Date of Exam** _____

Medication Prescribed _____ **Dosage** _____

Schedule and Method of Administration _____

_____

Comments _____

Physician's Signature _____ **Parent/Guardian Signature**_____

The prescription container must be clearly labeled with the following information:

a. Participant's full name
b. Physician's name
c. Physician's phone number
d. Name of Medication
e. Dosage
f. Expiration date of RX