



Immaculata Catholic School Emergency Treatment Authorization

Student's Last Name _____ First Name _____ Homeroom _____

Address _____ City _____ State _____ Zip _____

Male Female DOB _____

Does your student have any of the following medical conditions?

Circle One

Diabetic	yes	no		
Hard of hearing	yes	no		
Hyperactive	yes	no	Is the student currently on medication?	yes no
Heart Disorder	yes	no	Please explain below.	
Kidney Disorder	yes	no	Please explain below.	
Convulsive Seizures	yes	no	Is the student currently on medication?	yes no
Allergies	yes	no	Please explain below.	

Any other conditions the school should be aware of? Please explain below (continue on back if necessary).

Kindergarten – Grade 8 only	(does not apply to Prekindergarten)
Initial those allowed:	
I authorize the principal or principal designee to: _____ orally take child's temperature	
I authorize the principal or principal designee to give the following over-the-counter medications on an as needed basis:	
_____ Acetaminophen	_____ Ibuprofen
_____ Cough lozenges	_____ Benadryl
_____ Polysporin ointment	

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury. I understand this authorization will only be enforced with my consent or when I cannot personally be contacted and provide for immediate treatment.

Signed (Parent/Guardian)

Date