

**River City Rhythm**  
**Permission for Emergency Care & Student Health Form**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Father's Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Company under which student is covered: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Does your insurance require precertification? Y N Phone # for precertification if different from above: \_\_\_\_\_

Name of student's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the student allergic to any medications? If so, please list: \_\_\_\_\_

Is the student under physician's care for health needs on a continuing basis? Y N

Is the student under medication or treatment on a continuing basis? Y N

If yes to either of above, please explain and list all medications currently being taken and dosage schedule:

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

Is the student allowed to self-administer the medication? Y N

Date of last tetanus shot: \_\_\_\_\_ Food allergies: \_\_\_\_\_

Does the student require a special diet or prefer vegetarian? \_\_\_\_\_

**I GIVE THE CHAPERONES PERMISSION TO ADMINISTER THE FOLLOWING *OVER THE COUNTER* MEDICATIONS IF NECESSARY:**

Advil: \_\_\_\_\_ Tylenol: \_\_\_\_\_ Benadryl: \_\_\_\_\_ Imodium: \_\_\_\_\_ Sinus/Cold meds: \_\_\_\_\_ Pepto Bismol: \_\_\_\_\_

Imitrol: \_\_\_\_\_ Bonine (for motion sickness): \_\_\_\_\_ Midol: \_\_\_\_\_

Other (please list): \_\_\_\_\_

Please give permission for all medications which are not problematical to your child; otherwise we can't administer any medications that haven't been checked on this form without contacting you.

**I GIVE THE CHAPERONES MY PERMISSION TO CALL MY CHILD'S PHYSICIAN OR ANOTHER PHYSICIAN IN AN EMERGENCY WHEN MY CHILD'S PHYSICIAN OR I CANNOT BE CONTACTED. THEY ALSO HAVE MY PERMISSION, IN AN EMERGENCY WHEN I (OR MY CHILD'S PHYSICIAN) CANNOT BE CONTACTED, TO TAKE MY CHILD TO THE EMERGENCY ROOM OF THE NEAREST HOSPITAL, AND THE HOSPITAL AND ITS MEDICAL STAFF HAVE MY AUTHORIZATION TO PROVIDE TREATMENT THAT A PHYSICIAN DEEMS NECESSARY FOR THE WELL-BEING OF MY CHILD.**

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

If there is additional information you feel would be helpful to share with us, please use the back side of this form. Thank you!