



Summit School Routine Treatment and Emergency Release Form 2011-2012 School Year

Please complete both sides of this form

Student _____ Birth date _____ 2011-12 Grade _____

Age _____ Height _____ Weight _____ Wears glasses contacts

Treatment will be limited to first aid. Students who are vomiting, have uncontrolled diarrhea, or have a fever of 100 or greater will be sent home. Students will be expected to remain home until they have been fever free (without medication) and without vomiting for 24 hours. Parents will be notified immediately in the event of an emergency and the student may be sent home, recommended for doctor evaluation or, in cases of severe injury or illness, sent to the emergency room by ambulance.

Allergies--Documented reactions to drug, food, insect bite, or environmental exposure that warranted an evaluation by a health care provider.

Please specify _____

List Medications Routinely Taken _____

List Special Health Concerns (asthma, diabetes, cardiac etc.)

Students with rescue medications must have medications in the nurse's office and authorizations and instructions from their health care provider.

Emergency Information

Parent 1 _____ Parent 2 _____

Home phone _____ Home phone _____

Work phone _____ Work phone _____

Cell phone _____ Cell phone _____

Pager _____ Pager _____

In the event I cannot be reached, please contact _____

Home phone _____ Cell phone _____

Student's Health Care Provider _____ Office phone _____

Local hospital preference Baptist/Brenner Children's Hospital Forsyth Medical Center

Medical Insurance Carrier & Policy Number _____

Student's Dentist _____ Office phone _____

I _____, of _____
Parent/Guardian Address

City of _____, County of _____ State of _____,

am the parent/legal guardian of _____, a minor who attends
Student's name

Summit School, 2100 Reynolda Road, Winston-Salem, North Carolina

I give consent for emergency medical treatment including:

1. Administration of any emergency treatment to the minor deemed necessary by a licensed physician, dentist or other health care provider; and
2. Transfer of the minor to any hospital reasonably accessible.

This authorization does not cover invasive surgery upon the minor unless the medical opinions of two licensed physicians concurring on the necessity of such surgery are obtained prior to the performance of such surgery.

I hereby release Summit School and Summit School staff from any and all damages for injuries or illness occurring from treatments and ordered medications given to my child during school hours or activities. To the best of my knowledge all of the above information is accurate and complete. I hereby authorize the school nurse to share this information as needed for the safety and welfare of my child during the school year. To comply with privacy regulations, Summit School will only disclose student Protected Health Information with this written authorization from parents or legal guardians.

This _____ day of _____, 2011

Signature of Parent or Legal Guardian