PHOENIX CHRISTIAN
SCHOOL PRE K – 8

Medication Consent Form

____
Student Name   Date of Birth   Date

I, ____, give permission to the school to administer
(parent/guardian)

Please initial after each dosage or medication to be administered

- Acetaminophen   160 mg _____   325 mg _____

Dispensed for general use for mild pain or fever (102 degrees or above when parents cannot be reached). It may also be dispensed for functional menstrual pain and relief of minor headache. Dosage is as directed on the bottle according to age and weight of the child.

Exceptions:
____

- TUMS 750mg (1 tab) ❑

Dispensed for complaints of heartburn, sour stomach, acid indigestion, and/or upset stomach. Dosage is as directed on the bottle according to the age of the child.

Exceptions
____

- First Aid Cream (minor cuts / scrapes) _____
- Anti-Itch Cream (minor rash / insect bite) _____

Exceptions:
____

____
Parent/Guardian Signature   Date

Prescription Medication Consent Form
(one form for EACH medication is required)

Name of Student____ Grade___________

Physician Name____ Phone #_______________

Medication _______________________________ Rx # ______________________________

Dose__________________________ Route _________________________

Frequency_____________________________

Dates to be given ____________ to _____________

Precautions/Side Effects ____

Inhalers and EPI PENS

- **Asthma Inhaler**: This student is capable of self-administration and may carry inhaler and self-administer at school YES NO
- **EPI-PEN**: EPI-PENS will be administered by school personnel. Please provide in original packaging with STUDENT NAME on the pen.

____

Parent/Guardian Signature Date

CDC/SGH# or name:___________________

Arizona Department of Health Services

Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):___________________

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

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Medical Information

Is child allergic to food or other substances? **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs	☐ **No**	☐ **Yes**
Is child usually susceptible to infections and if so, what precautions need to be taken? **If yes**, list precautions:	☐ **No**	☐ **Yes**
Is child subject to convulsions and what should be our procedure if one occurs? **If yes**, specify procedure:	☐ **No**	☐ **Yes**
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **If yes**, list precautions:	☐ **No**	☐ **Yes**
Additional comments:		
Other special instructions:		

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**