

PCUS HEALTH HISTORY / CONSENT FOR MEDICAL TREATMENT 2010—2011

Student's Last Name _____ First Name _____ Grade _____

Y	N	Has this student ever had...	Y	N	Has this student ever had...	Y	N	Has this student ever had...	Y	N	Has this student ever had...
		01. Allergies			11. Epilepsy (Seizures)			21. Elbow Injury			31. Migraine Headaches
		02. Anemia			12. Fainting			22. Knee Injury/Surgery			32. Mononucleosis
		03. Arthritis			13. Operations			23. Neck Injury			33. Rheumatic Fever
		04. Asthma			14. Hearing Trouble			24. Spine Injury			34. Scoliosis
		05. Back Pain			15. Heart Murmur			25. Wrist Injury			35. Sinus Trouble
		06. Concussion			16. Hepatitis			26. Fractures			36. Sore Throats (Chronic)
		07. Loss of Consciousness			17. Hernia (Rupture)			27. Joint Pain			37. Tuberculosis
		08. Diabetes			18. Hives			28. Kidney Trouble			38. Valley Fever
		09. Eczema			19. Dislocations/Sprains			29. Knocked Out			39. Other
		10. Emotional Problems			20. Ankle Injury			30. Menstrual Cramps			

PLEASE EXPLAIN COMPLETELY EVERY "YES" ANSWER ABOVE:

Date of last Tetanus Booster: _____

Name of Family Insurance: _____

Did you purchase School Insurance? Yes No

To which medicines/ foods is student allergic? _____

Medications now being taken: _____

YOU MUST INITIAL beside each medication you would like available to your student while at school. [JH/SH Students Only]

_____ **Benadryl** (or its generic equivalent) : 25 mg tablets
recommended dose: 1-2 tablets every 4-6 hrs

_____ **Advil** (or its generic equivalent): 200 mg tablets recom-
mended dose: 1-2 tablets every 4-6 hours

_____ **Midol** (or its generic equivalent): 200 mg tablets recom-

mended dose: 1 tablet initially; if pain does not respond,
2 tablets may be used

_____ **Sudafed** (or its generic equivalent): 30 mg tablets
2-4 tablets hourly as needed

_____ **Tylenol** (or its generic equivalent): 325 mg tablets

The undersigned hereby give permission for the above named student to attend any school-related function for the period from August 1, 2010 to July 31, 2011. In the event there is any emergency involving him/her, permission is hereby granted for Phoenix Christian Unified Schools personnel to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon or dentist licensed to practice in any state, and school personnel shall not be held personally liable.

If emergency service involving medical action or treatment is required, and neither the parent nor guardian can be contacted, the undersigned herewith consents for the student named above to be given medical care by a doctor selected by the school. Any intentional omission or falsification of this form may subject the parent/guardian to full liability for any subsequent injury, or may cause the student to be removed from sports participation.

The undersigned gives consent for the above over-the-counter medications (if initialed above) to be administered by a designated school employee as needed, as determined by the employee. The parent/guardian must complete a written authorization form provided by the school for prescription medications that will be taken at school. All prescription medications must be turned in to the nurse's office in the container dispensed by the pharmacy.

Mother/Guardian Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Father/Guardian Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Name of Relative/Friend in Case You Cannot be Contacted _____ Relationship _____

Phone _____ Work Phone _____ Cell Phone _____

List any individual(s) who SHOULD NOT pick up and/or have contact with your student:

1. _____
2. _____

Signature of Parent or Legal Guardian

(Must Sign in Presence of Notary Public)

State of Arizona, County of Maricopa

Subscribed and sworn to before me

This _____ day of _____

Notary Public _____

My Commission Expires _____