RISING GROUND
Paths to positive change since 1831

463 Hawthorne Avenue
Yonkers, NY 10705
914-375-8700

1529-35 Williamsbridge Road
Bronx, NY 10461
718-794-8200

RisingGround.org

EMERGENCY CONTACT FORM

This form must be completed by Parent/Legal Guardian and returned before the student start of class, for the school year. Please print all information in blue or black ink.

Student Name: _____ Grade _____

Gender: Male___ Female ____ Date of Birth _____

Name of Legal Guardian: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Work Number: _____ Other Number: _____

IF Student is a child in foster care, please fill out the following:

Foster Parent Name: _____ Contact # _____

Name of Agency: _____

Name of Caseworker: _____

Caseworker's Phone #: _____ Agency 24 hour #: _____

Emergency Name and Telephone Number of friend or relative to contact if parent/guardian cannot be reached:

1. Name: _____ Home Number: _____ Cell Number: _____
2. Name: _____ Home Number: _____ Cell Number: _____

IF Parent / Legal Guardian are not available for pickup, who do you authorize to pick up the student?

Name: _____ Home Number: _____ Cell Number: _____

Name: _____ Home Number: _____ Cell Number: _____

_____ _____

Parent / Legal Guardian Signature **Date**

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MEDICAL CONTACT / INFORMATION

Student Name: _____ **DOB:** _____

Primary Care:

Name of Family Physician or Pediatrician: _____

Address: _____

_____

Office Number: _____ Fax Number: _____

Specialty Care:

Name of Medical Specialist: _____

Address: _____

_____

Office Number: _____ Fax Number: _____

What is the reason that the child sees this physician? _____

Name of Therapist or Psychiatrist: _____

Address: _____

_____

Office Number: _____ Fax Number: _____

CONSENT FOR MEDICAL TREATMENT

____ **I GIVE my permission for the School Nurse to administer First Aid as needed.**

____ **I DO NOT Give permission for the School Nurse to administer First Aid as needed, would like my child to be taken to the local Emergency Room for First Aid.**

In IMMEDIATE situations, the student will be taken to the local Emergency Room for treatment.

Signature of Parent/Legal Guardian: _____ **Date:** _____

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TUBERCULIN TESTING

Name: _____ Date: _____

Not Indicated (*if checked, complete this section*) _____

Date of last Chest X-Ray: _____

Referred for Chest X-Ray: _____

History of POSITIVE PPD or BCG _____

Date of previous Treatment, if any: _____

TESTING:

MD Order: Date: _____

Inject 0.5 units subcutaneously and read in 48 to 72 hours

MD Signature: _____

Date Placed: _____ **Site: (circle)** Left Arm Right Arm

Lot Number: _____ Expiration Date _____

Placed By:

Nurse's Signature: _____ **Print Name:** _____

Date Read: _____

Result: _____mm induration _____Negative _____Positive

Read by:

Nurse's Signature: _____ **Print Name:** _____

Statement Prohibiting the Disclosure of Confidential Information

The following information has been disclosed to you from confidential records, which are protected, by New York State Law OMH 33.13 and / or Federal Regulations 42 CPR Part 2. Disclosure of this information without specific written consent of the person to whom it pertains, or their legal guardian, is strictly prohibited. Any unauthorized disclosure of this information is in violation of the law and may result in serious legal consequences including fines or a jail sentence or both.
A general authorization for the release of medical or other information is not acceptable for further disclosure.
Disclosure of Confidential HIV information that occurs as a result of a general authorization for the release of medical or other information is in violation of the law and may result in serious legal consequences including fines or a jail sentence or both.

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MEDICATION ADMINISTRATION FORM: PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

Student's Name: _____ DOB: _____

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

_____ **I understand that no student will be allowed to carry or self-administer medication.**
Initial

_____ **I understand that this Authorization is only valid for the current school year.**
Initial

_____ I authorize the school nurse to store and/or administer all physicians prescribed medication to my child.
Initial

_____ I **DO NOT** authorize the school nurse to store and / or administer all physician prescribed medications to my child. Therefore, I understand my child will not receive medication in school.
Initial

Please Print:
Parent/Guardian's Name: _____
Address: _____
_____
Day-time Telephone No. _____
Home Telephone No. _____

Parent/Guardian's Signature: _____

Date Signed _____

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SCHOOL MEDICAL CLEARANCE FORM

Student Name: _____ **DOB:** _____ **Sex:** _____

History:

Allergies:

Medications:

Physical Exam	Normal	Abnormal	Comment (for abnormal findings)
HEENT			
Neck			
Skin			
Pulmonary			
Cardio Vascular			
Abdominal			
Genital-Urinary			
Extremities			
Neurological			
Lymph			

Immunizations: [attach record or titers] UTD: ___Yes ___No
PPD: Date: ___/___/___ ____Neg. ____Pos. [If Pos. ____CXR, _____Result]
Last Dental Exam: Date: ___/___/___ Vision Exam: OD _____ OS _____
Hearing Exam: Right _____ Left: _____

Assessment:

Medically Cleared for Sports: ___Yes ___No **Cleared for Football: ___Yes ___No**

PLEASE SUPPLY PRESCRIPTION COPIES OF ALL MEDICATIONS, INCLUDING OTC / PRN, TO BE GIVEN IN SCHOOL, WITH DETAIL DIRECTIONS WITH PRESCRIBER CONTACT.

Physician Signature **Physician Stamp** **Date**

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SCHOOL MEDICATION PRESCRIBER AUTHORIZATION

Student Name: _____ **DOB:** _____ **Sex:** _____

List any known allergies/reactions:

_____

_____

Physician Name: _____
Physician Address: _____
Physician Telephone and Fax: _____

Name of Medication: _____
Reason for Taking: _____
Dosage Route Frequency/Time(s) to Be Given _____
Begin Medication _____ Stop Medication _____
Date Date
Potential Side Effects/Contraindications/Adverse Reactions _____

Name of Medication: _____
Reason for Taking: _____
Dosage Route Frequency/Time(s) to Be Given _____
Begin Medication _____ Stop Medication _____
Date Date
Potential Side Effects/Contraindications/Adverse Reactions _____

Name of Medication: _____
Reason for Taking: _____
Dosage Route Frequency/Time(s) to Be Given _____
Begin Medication _____ Stop Medication _____
Date Date
Potential Side Effects/Contraindications/Adverse Reactions _____

Special Instructions:

Does medication require refrigeration? Yes No
Is the medication a controlled substance? Yes No
If asthma inhaler or emergency medication, do you recommend this medication be kept "on person" by the student? Yes No
Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

If PRN medication is prescribed for student, please attached order for each PRN medication with medication name, dose, frequency, route and indications.

For FEMALE students during menses, if PRN medication is advised, please provided order with medication name, dose, frequency, route and indications.

_____

Physician Signature **Physician Stamp** **Date**