3000 E Garner Rd Raleigh, NC 27610 (Elementary Campus) 919-553-7652
Mailing Address: 1696 Amelia Church Road Clayton, NC 27520 (MS/HS Campus) 919-585-6742
www.scswarriors.com

SCS MEDICAL INFORMATION
EMERGENCY RELEASE FORM 2024-2025

Instructions: Elementary school parents should complete and email this form to Christa Honeycutt at choneycutt@scswarriors.com and middle and high school parents should email Colleen Krauss at ckrauss@scswarriors.com. Please note: the Medical Information/Emergency Release Form is required to be on file before the student will be allowed to attend field trips or the Student Retreat.

Student Legal Name

_____/_____/_____/_____
Last First Middle Preferred

Address _____ City _____ State _____ Zip _____

Date of Birth _____/____/____Gender: ☐ M ☐ F Student Cell # _____ Grade *Entering* _____

FAMILY INFORMATION (please print clearly in black or blue ink)

	Name	Legal Guardian	Cell Number	Work Number
Mother		☐ Y ☐ N		
Father		☐ ☐		
Step-Parent		☐ ☐		
Guardian		☐ ☐		

EMERGENCY CONTACTS

Name: _____ Home: _____ Cell: _____

Name: _____ Home: _____ Cell: _____

	Name	**Phone**
Pediatrician/primary care provider		
Hospital of choice		
Dentist		

Insurance Company: _____

Policy Number: _____ Phone: _____

(In case of accident or serious illness, the school will attempt to contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: (please print) _____

HEALTH HISTORY – 2024-25 MEDICATION AUTHORIZATION FORM

Student Name: _____ Grade (2024-25) _____

List any health information (past and present such as diabetes, asthma, allergies, seizures, migraines, ADD/ADHD, etc.) Also, please list any current medications that your child is taking.

_____

_____

Date of last Tetanus _____

TO BE COMPLETED BY A PHYSICIAN **Authorization for medications to be administered during the academic day and school sponsored events.**

SECTION 1: Please check the following OTC (Over the Counter) medication(s) that the student may be given and list any prescription medications to be given during the school year.

Tylenol/generic ___Yes ___ No
Motrin/generic ___Yes ___ No
Benadryl (for allergic reactions) ___ Yes ___ No

SECTION 2: Please complete the following for any prescription medication or additional OTC (i.e. allergy medication, etc.) to be given during the 2024-25 school year.

The above name of student is under my care for (diagnosis): _____

Medication to be administered during school hours: _____

Dosage/Route/Frequency: _____ Administration to begin: _____ Administration to end: _____

Possible side effects: _____

EMERGENCY MEDICATIONS (i.e. EpiPen, inhaler, etc.) may be carried by the student and self-administered if the physician indicates below and considers the student sufficiently responsible. **ACTION PLAN REQUIRED**. Parents should supply the School Office with additional emergency medications as a precaution.

ALLERGIES: Please list allergic reactions that may require emergency medication treatment: (i.e food, drug, seasonal or allergic reactions to bees/insects)

_____

Does the student carry and self-administer this medication for emergencies ___ Yes ___No

Please list any daily medications that the student will need to take during co-curricular activities (after school).

Medication	Dosage	Frequency/Time Duration	Medication	Dosage	Frequency/Time Duration

Signature of Physician, CRNP or PA: _____ Phone #: _____

Printed Name of Physician, CRNP or PA: _____ Date: _____

(The above medication order is valid 8/12/2024 – 6/5/2025)

An Action Plan form is required for students with a history of asthma, diabetes, allergic reactions or seizures requiring treatment. This form along with the SCS ALLERGY Action Plan must be completed by a physician. *Action Plan form may be obtained from the Office or under Admission Forms on the SCS website.

TO BE COMPLETED BY PARENT/GUARDIAN

I request the medication listed above be given to this student during school hours and all school sponsored events. Medications will only be accepted in the original container along with a doctor's signature for that medication. I understand that only I, or the school nurse or appointed school personnel, may administer this medication during school hours or school sponsored events to this student. I acknowledge that the school shall incur no liability as a result of any condition from the medication. I shall not hold the school, its employees or agents against any claims arising from the administration of medication given to this student.

Signature of Parent: _____ Date: _____

ALL MEDICATIONS WILL BE DISCARDED IF NOT PICKED UP BY JUNE 5, 2024.