



## SCS MEDICAL INFORMATION EMERGENCY RELEASE FORM 2025-2026

Instructions: Parents should complete and email this form to Christa Honeycutt at [choneycutt@scswarriors.com](mailto:choneycutt@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 – 2025-26 MEDICATION AUTHORIZATION FORM

Student Name: \_\_\_\_\_ Grade (2025-26) \_\_\_\_\_

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 2025-26 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 Yes NNo

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 8/11/2025 – 6/5/2026)

*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, 2026.**