Solano Valley Alumnae Chapter
DELTA SIGMA THETA SORORITY, INC.

MEDICAL INFORMATION AND TREATMENT AUTHORIZATION PACKET

Today's date: _____

Name of Minor (PRINT): _____

Date of Birth_____ Age _____

Address: _____

City/State/Zip Code _____

Parent/Guardian Home Phone _____

Cell Phone_____ E-mail Address_____

Minor's Gender _____Height _____ Weight _____

HEALTH INFORMATION

Below please check any current health condition that may require attention during the Program day. Also complete and submit the Medication Authorization Form if your child has health conditions that require medication during the Program day.

Asthma Inhaler required at Program: ☐ YES ☐ NO

Vision Problems: ☐ Glasses ☐ Contacts

Hearing Problems: ☐ Hearing Aid(s)

ADD/ADHD: ☐ YES ☐ NO

☐ Other _____

☐ Allergies/Sensitivities (be specific)

Foods_____

Medicines_____

Bee sting or insect bite_____ Other_____

List all medications and dosages your child receives on a continual basis: _____

_____

_____

_____

Health History:

Child's Name (Last, First, M.I.): _____

Gender (check one): Male ☐ Female ☐ DOB (mm/dd/yy): _____

Parent/Guardian Name: _____ Does Parent/Guardian live in home with child? ____

Parent/Guardian Name: _____ Does Parent/Guardian live at home with child? ____

Is/Has child been under the regular supervision of a physician? _____

Name, address, and phone number of physician: _____

_____

Date of last physical exam: _____

Health and Developmental History:

Childhood illness: Check any that apply

☐ Measles	☐ Mumps	☐ Asthma	☐ Chickenpox
☐ Rheumatic Fever	☐ Hay Fever	☐ Diabetes	☐ Epilepsy
☐ Whooping Cough	☐ Poliomyelitis	☐ Ten-Day Measles (Rubella)	
☐ Three-Day Measles (Rubella)			

Other (please list): _____

Does child have any significant health history, conditions, communicable illness, or restrictions that may affect child's participation in the Solano Valley Alumnae Chapter youth initiatives program? (Check one) ☐ None ☐ Yes

If yes, please provide detailed explanation: _____

_____

Does child have any significant food/medication/environmental allergies that may require emergency medical care at the Solano Valley Alumnae Chapter youth initiatives program? (Check one) ☐ None ☐ Yes

If yes, please provide detailed explanation: _____

_____

Specify any other serious or severe illnesses or accidents: _____

_____

Does child take prescribed medications? Name the medications: _____

_____

Frequency Taken: _____ (For any medications or treatment required during the course of the Solano Valley Alumnae Chapter youth initiatives program, a Medication Authorization Form should be completed and submitted with this form.)

Does child take any over the counter medications frequently? ☐ Yes ☐ No

Name of the medications: _____

_____

Frequency Taken: _____

NON-PRESCRIPTION MEDICATION PERMIT

PLEASE CHECK those medications you give permission for your child to receive (generic equivalent may be used) as ordered by a physician/healthcare provider. **A completed Medication Authorization Form must be on file with the Program. It is the responsibility of the parent/guardian to furnish medication in the original appropriately labeled container.** I/We understand that medications will be administered with discretion by an authorized Solano Valley Alumnae (SVA) chapter member or Program volunteer and in accordance with established protocols developed by the Program.

The following nonprescription medications may be available to your child:

☐ **For headaches/fever/muscle aches/pain/cramps**: Acetaminophen (e.g., Tylenol, including Junior Strength), Ibuprofen (e.g., Advil, including Children's liquid, Motrin), Naproxen (Aleve), Midol, & Excedrin

☐ **For bites/allergic rashes**: Anti-itching lotion (e.g., Calamine or Hydrocortisone cream 1%), Benadryl liquid

or capsules.

☐ **For nasal congestion/sinus pressure**: Decongestant

☐ **For sore throat**: Throat lozenges (e.g., Cepacol lozenges)

☐ **For coughs**: Cough drops/lozenges or cough suppressant.

☐ **For upset stomach**: Antacid liquid or chewable tablets (e.g., Mylanta)

☐ **For sun protection**: Sunscreen lotion SPF 30.

☐ **I DO NOT WANT ANY MEDICATIONS GIVEN TO MY CHILD.**

Parent/Guardian Signature _____ **Date**_____

PHYSICIAN/HEALTHCARE PROVIDER & INSURANCE INFORMATION (PLEASE PRINT)

Name of Child's Physician/Healthcare Provider _____ Phone_____

Health Insurance Company_____ Phone_____

Policy Number _____ Group Number _____

Insurance Company Address_____

City/State/Zip Code_____

Name of Policy Holder_____

Name of Policy Holder's Employer _____

EMERGENCY CONTACT INFORMATION **(PLEASE PRINT)**

Parent/Guardian #1

Name_____Relationship_____

Street Address_____

City_____ State _____Zip Code _____

Home Phone_____ Work Phone _____Cell Phone _____

E-mail address_____

Parent/Guardian #2

Name_____Relationship_____

Street Address_____

City_____ State _____Zip Code _____

Home Phone_____ Work Phone _____Cell Phone _____

E-mail address_____

If for any reason I/we cannot be reached, please contact the following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child.

Name: _____ Relationship to Student _____

Home Phone_____ Work Phone _____ Cell Phone _____

Name: _____ Relationship to Student _____

Home Phone_____ Work Phone _____ Cell Phone _____

In the event that the Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the Program to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

MEDICATION ADMINISTRATION PROCEDURES

Prescription Medication

1. We require the Medication Authorization Form to be completed by the prescribing physician and the parent. For each prescription medication ordered, the physician must give the following information: (1) the student's name, (2) the medication, (3) the dosage, (4) the time of administration, (5) the reason for administration, (6) the route of administration, (7) the possible side effects, and (8) any other significant information. The form must then be signed and dated by the prescribing physician. Signed parental consent is also required for each medication. This consent releases Delta Sigma Theta Sorority, Incorporated, the Solano Valley Alumnae Chapter youth initiatives program, and their officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, and assigns from liability if the medication causes adverse reactions. The Medication Authorization Form is updated annually.

2. The original prescription container must accompany all medication to be given at the Solano Valley Alumnae (SVA) Chapter youth initiatives program. Medications should be brought to the Solano Valley Alumnae Chapter youth initiatives program by the parent or responsible adult and taken to a SVA Chapter member. The original prescription container should be labeled with the following information: name of student, name of medication, dosage of medication to be given, frequency of administration, route of administration, name of physician/healthcare provider ordering medication, date of prescription, and expiration date.

3. If possible, the parent should provide _____ days worth of the medication if it is to be given every day. It is the parent's responsibility to provide adequate refills on a timely basis.

4. All medication is kept in a locked cabinet or locked container at all times. If not retrieved by a parent or responsible adult, all medication will be destroyed one week after the expiration date or at the end of the term for the Solano Valley Alumnae Chapter youth initiatives program.

5. A record will be maintained every time a medication is given. The record includes the student's name, date, time of administration, and dosage.

Over-the-Counter Medication

1. A physician/health care provider's order is required in order to administer over-the-counter medication. It is the responsibility of the parent/guardian to furnish medication in the original appropriately labeled container.
2. Written parental consent for the administration of over-the-counter medication is obtained through the emergency/medication authorization forms.
3. A record will be maintained every time a medication is given. The record includes the student's name, date, time of administration, and dosage.

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MEDICATION AUTHORIZATION FORM

(*To be filled out by the physician/healthcare provider dispensing the medication*)

Name of Minor_____ Birthdate _____

Medication_____

Dosage_____

Time of administration_____

Reason for medication_____

Route of administration _____

Possible side effects and significant information_____

_____

_____

Physician/Healthcare Provider Name (PRINT): _____

Physician's/Healthcare Provider signature: _____

Physician's/Healthcare Provider telephone number: _____ Date: _____

PARENTAL PERMISSION FORM ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for _____ to take _____at the Solano Valley Alumnae (SVA) Chapter youth initiatives program as ordered by his/her physician/ healthcare provider identified above.

I/We understand that it is my/our child's responsibility to report to a Solano Valley Alumnae Chapter member at the appropriate time for the administration of the medication.

I/We further understand that it is my/our responsibility to furnish this medication and any authorized refills. I/We further understand that Delta Sigma Theta Sorority, Incorporated ("DST"), its officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, assigns, the Solano Valley Alumnae Chapter youth initiatives program, its agents, and/or any employee who administers any drug to my/our child, in accordance with written instructions from the prescriber, shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my/our child due to the administration or failure to provide the drug.

The Solano Valley Alumnae Chapter youth initiatives program reserves the right to refrain from administering

medication if in the judgment of the Solano Valley Alumnae Chapter youth initiatives program, or other authorized Program officer, agent, or employee the circumstances do not warrant medication administration.

I/We understand that the medication must be brought to the Solano Valley Alumnae Chapter youth initiatives program by me/us in the original appropriately labeled container.

If I/we cannot bring the medication to the Solano Valley Alumnae Chapter youth initiatives program, I/we will call the Solano Valley Alumnae Chapter youth initiatives program at (707) 246-7401 or (707) 685-3506 to inform them that my/our child will be bringing it, indicating the amount of medication in the container.

Parent/Guardian's Signature: _____ **Date**: _____

Parent/Guardian's Name (PRINT): _____

Telephone: _____ **(home)** _____ **(cell)**