

Consent/Release Form
MORAVIAN ACADEMY - UPPER SCHOOL
4313 GREEN POND ROAD, BETHLEHEM, PA 18020

NOTE: Any medications to be taken by the student must be delivered to the school nurse, properly labeled with the student's name, dosage and physician's instructions. **SELF MEDICATION IS NOT PERMITTED.** No medications may be kept by the student; they must be kept with and dispensed by the school nurse.

PLEASE READ AND ENDORSE THE FOLLOWING CONSENTS AND MEDICAL RELEASE:

1. THE SCHOOL NURSE HAS MY PERMISSION TO PROVIDE CARE AND TREATMENT FOR MY CHILD THAT SHALL INCLUDE: INJURIES, ILLNESSES, AND THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION (THAT MAY INCLUDE BUT NOT BE LIMITED TO TYLENOL, IBUPROFEN, ANTACIDS, COUGH DROPS) ONLY WHEN THE NURSE FEELS IT IS NECESSARY FOR MY CHILD'S WELFARE DURING THE SCHOOL YEAR. (Please list any restrictions you have on the type(s) of over-the-counter medication you want your child to receive. If no consent is given, your child will not be given any medication unless you can be reached by phone for consent.)

Signature of Parent/Guardian

Date

2. IN THE EVENT THAT I CANNOT BE REACHED, I AUTHORIZE THE SCHOOL ADMINISTRATOR OR A FACULTY MEMBER TO DESIGNATE A DOCTOR AND/OR HOSPITAL TO INITIATE APPROPRIATE EMERGENCY MEDICAL SERVICES. THE SCHOOL REPRESENTATIVE HAS THE RIGHT TO AUTHORIZE THE PHYSICIAN IN CHARGE OF MY CHILD'S CARE TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSES AND TREATMENT OF THE STUDENT IN AN EMERGENCY SITUATION.

I RELEASE FROM ANY LIABILITY MORAVIAN ACADEMY, THE COACHES AND FACULTY AND ANY OTHER EMPLOYEES OF MORAVIAN ACADEMY FROM ANY EXPENSES, CHARGES, OTHER COSTS OR CLAIMS FOR DAMAGES OR INJURY BECAUSE OF THE STUDENT'S PARTICIPATION IN THE SCHOOL'S PROGRAMS.

Signature of Parent/Guardian

Date

3. THE SCHOOL NURSE HAS MY PERMISSION TO SHARE MEDICAL INFORMATION, SPECIFIC TO MY CHILD, WITH MORAVIAN ACADEMY PERSONNEL ON A NEED TO KNOW BASIS WHEN THERE IS A DETERMINED LEGITIMATE EDUCATIONAL INTEREST.

Signature of Parent/Guardian

Date

(ALL STUDENTS MUST HAVE MEDICAL/HEALTH INSURANCE AND THE POLICY INFORMATION MUST BE COMPLETED BELOW.)

HEALTH INSURANCE - Policy Holder _____

Address _____

I UNDERSTAND THAT I/WE ARE FULLY RESPONSIBLE FOR ALL MEDICAL INSURANCE AND/OR OTHER EXPENSES RESULTING FROM ACCIDENTS, INJURIES AND/OR ILLNESSES.

Signature of Parent/Guardian

Date