## Blended/ Testing Medical Information Form

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| **Testing Date:** | **Testing Site:** |  |
| **Student’s Full Name:** | **Grade Level:** |  |
| **Name of school Student Attending:** |  | |

**IMPORTANT INFORMATION:**

1. I exempt the school, its employees and authorized sponsors and volunteers from all claims arising from the student's participation in the above identified activity unless caused by actions for which the School District would otherwise be liable under Colorado law.
2. I understand and give full authority for the school to take whatever action it deems necessary to safeguard the health and well-being of the participating student including, but not limited to, consenting to emergency medical care.

**INSURANCE:**

I understand the school does not purchase, or have, any insurance to cover medical, dental or hospitalization to cover injuries to or loss of life of students, damage to or loss of personal property or to indemnify parents/guardians for any expenses in connection therewith, and that if any insurance is desired, it must be purchased by the parent/guardian.

**EXPECTED STUDENT CONDUCT:**

**Students of K12 attending Colorado Preparatory Academy, Pikes Peak Online School, or Destinations Career Academy of Colorado have the responsibility to maintain the same behavior standards expected of them while they are in school and are subject to consequences for breaches of such standards just as though they were in school.**

**INSTRUCTIONS TO PARENT:**

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child’s health practitioner review the information you provide below and sign and date where indicated.

**MEDICAL CONDITION(s):**

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Medications currently being taken by your child:

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| Please allow the above medications to be carried and self-administered at school functions. (I as parent / legal guardian give my consent for my **Student (name) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to self-administer medication as needed).  **Parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medication needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ time of Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **All medications MUST be a Prescription issued by a Doctor or Pharmacy with student’s name, packaged in the original container, and have a current date within 30 days of school function. Please check the container in before testing with the Site Coordinator. This medication may NOT be administered to any other student or staff.**  **In signing, I relieve the school or school district employee of any responsibility for the benefits or consequences of the self –administered medication, and understand that the school or employees bear no responsibility for ensuring that the medication is taken.** |
| Side Effects and treatment self-administered medication if needed: |

Allergies/Reactions:

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**EMERGENCY MEDICAL INSTRUCTIONS:**

Signs/symptoms to look for:

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If signs/symptoms appear, do this:

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To prevent incidents:

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

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