NAPLES CHRISTIAN ACADEMY

MEDICAL PERMISSION AND RELEASE FORM
2025-2026

CHILD #1_____ AGE _____ GRADE _____

CHILD #2_____ AGE _____ GRADE _____

CHILD #3_____ AGE _____ GRADE _____

CHILD #4_____ AGE _____ GRADE _____

CHILD #5_____ AGE _____ GRADE _____

Family Physician _____ Phone # _____

Insurance Company _____ Policy # _____ Policy Holder Name _____

DIETARY PREFERENCE: _____

KNOWN ALLERGIES / MEDICAL CONDITIONS

CHILD # 1_____

❒ FOOD ❒ PENICILLIN/DRUGS ❒ INSECT STINGS/BITES ❒ PREVIOUS SERIOUS ILLNESSES ❒ CURRENT MEDICATIONS

❒ SPECIAL DIET _____

CHILD # 2_____

❒ FOOD ❒ PENICILLIN/DRUGS ❒ INSECT STINGS/BITES ❒ PREVIOUS SERIOUS ILLNESSES ❒ CURRENT MEDICATIONS

❒ SPECIAL DIET _____

CHILD # 3_____

❒ FOOD ❒ PENICILLIN/DRUGS ❒ INSECT STINGS/BITES ❒ PREVIOUS SERIOUS ILLNESSES ❒ CURRENT MEDICATIONS

❒ SPECIAL DIET _____

CHILD # 4_____

❒ FOOD ❒ PENICILLIN/DRUGS ❒ INSECT STINGS/BITES ❒ PREVIOUS SERIOUS ILLNESSES ❒ CURRENT MEDICATIONS

❒ SPECIAL DIET _____

CHILD # 5_____

❒ FOOD ❒ PENICILLIN/DRUGS ❒ INSECT STINGS/BITES ❒ PREVIOUS SERIOUS ILLNESSES ❒ CURRENT MEDICATIONS

❒ SPECIAL DIET _____

AUTHORIZATION FOR ADMINISTRATION OF O.T.C. MEDICATIONS

CHILD #1_____ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop
❒ Neosporin ❒ Benadryl Spray

CHILD #2_____ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop
❒ Neosporin ❒ Benadryl Spray

CHILD #3_____ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop
❒ Neosporin ❒ Benadryl Spray

CHILD #4_____ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop
❒ Neosporin ❒ Benadryl Spray

CHILD #5_____ ❒ Advil/Motrin ❒ Tylenol ❒ Cough Drop
❒ Neosporin ❒ Benadryl Spray

Please complete the back of this form

I HEREBY AUTHORIZE NAPLES CHRISTIAN ACADEMY TO TAKE MY CHILD TO ANY HOSPITAL OR LICENSED PHYSICIAN FOR MEDICAL TREATMENT IN THE EVENT OF AN EMERGENCY IN WHICH NEITHER PARENT CAN BE REACHED.

_____

Parent/Guardian Printed Name Parent/Guardian Signature Date

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN OR MEDICAL TREATMENT CENTER TO TREAT MY CHILD IN CASE OF AN EMERGENCY IN WHICH NEITHER PARENT CAN BE REACHED.

_____

Parent/Guardian Printed Name Parent/Guardian Signature Date

***Prescription Medication Policy* – NOTE - Prescription medication MUST be in the original container with a label showing the prescribed dosage and name of student. For insurance liability reasons, students are not permitted to administer their own medications.**

Student Name _____ Prescription Medication _____

Time to be administered ❒_____ a.m. ❒_____ p.m.