



# NOBLE

## MEDICAL FORM

*This form must be completed for all new students entering a campus of the Noble Network of Charter Schools.*

Student's Legal Name: \_\_\_\_\_  
(First) (Middle) (Last)

### I. DECLARATION OF MEDICAL OR ALLERGY CONDITION

**Disclaimer:** For confidentiality purposes, this information will only be shared with relevant staff. Thank you for your cooperation in this important matter.

Does your student have a current medical or allergy condition?

No, my student has NO allergies, medical conditions, and/or does not take any medication during school hours. **Please move on to section II of this form.**

Yes, my student DOES have allergies, medical conditions, and/or needs to take medication during school hours. **Please continue to complete section I of this form.**

Asthma                      Seizures                      Other: \_\_\_\_\_

Diabeties Type: \_\_\_\_\_                      Allergy Type: \_\_\_\_\_

**Please describe in detail the medical condition that has been checked above.** Your description should detail any medications required including EpiPens or asthma inhalers. If you have indicated your student has any food or non-food allergies, please describe in detail any and all reactions and severities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important:** If you made a selection above, we will need further information so our clinicians, school administration, and teachers can provide your student with any necessary accommodations.

Please check one of the options below:

I have read the above and have attached information to this form for the Noble campus to create a 504 plan (school accommodations) or an emergency action plan for my student due to their medical or allergy conditions.

I have read the above, and I DO NOT want the school to implement any accommodations or write an emergency action plan for my student's allergy or medical condition.

Parent/Guardian Initials: \_\_\_\_\_

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(MM) (DD) (YYYY)

**II. ADMINISTRATION OF MEDICATION POLICY**

If a student requires medication during school hours, administration of medications will be supervised by the Office Staff or School Nurse. Students are not allowed to have medications in their possession or in their locker. The ONLY exception is an EpiPen or an asthma inhaler.

In order to monitor any student's self-administration of prescribed medication(s), including EpiPens and asthma inhalers, we must have a "Physician Self-Administration" form on file (form available in main office). Prescription medications must be supplied in the original pharmacy container. The container must be identified with the following information: student's name, name of medication, doctor's name and phone number.

For over the counter medication(s), we must have a "Parent Self-Administration" form on file (form available in main office). Over the counter medications must also be supplied in the original container.

Students are responsible for coming to the main office to take their medication at the appropriate time.

**III. EMERGENCY FIRST AID**

In the event of an emergency, I hereby give permission to any campus of the Noble Network of Charter Schools to perform emergency first aid or any other medical procedure immediately necessary. Furthermore, I give permission for the school to make a plan for my student to be taken to an emergency room in the event of an emergency.

The school will attempt to contact the parent/guardian(s) first. It is the parent/guardian(s) responsibility to ensure that the school always has the most up-to-date, contact information.

**IV. ACKNOWLEDGMENT AND CONSENT**

I (we), the signee and the student's legal parent/guardian, declare the information provided on this form is complete and accurate. I (we) have read the above information and accept responsibility for following the school's policies regarding administration of medication (if applicable) and emergency first aid.

1st Parent/Guardian Printed Name: \_\_\_\_\_

1st Parent/Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM) (DD) (YYYY)

2nd Parent/Guardian Printed Name: \_\_\_\_\_

2nd Parent/Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM) (DD) (YYYY)

**OFFICE USE ONLY**

Referred to Case Manager? Yes No

Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM) (DD) (YYYY)

Entered By (initials): \_\_\_\_\_ Last Updated: 03/2018