EMERCENCY MEDICAL AUTHORIZATION FORM

Date:_____ Student Name: _____

Address: _____ Birthday: _____

Home Phone: _____ Cell Phone: _____

School Messenger Phone: _____
(The one number you would like to be contacted for the following: notification of absence, closing or delays, or various situations.)

Email: _____

Parents: ☐ Married ☐ Divorced ☐Separated ☐ Other, Please specify: _____

If divorced/separated/other, who is residential parent?: _____

Name of non-residential parent: _____

Address of non-residential parent: _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, or non-emergency incidents when parents or guardians cannot be reached.

Mother/Guardian Name: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Father/Guardian Name: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Other's Name: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Please list facts concerning the child's medical history, including allergies, medication being taken, and any physical impairments to which a physician should be alerted.

Allergies (Please list all allergies, type of reaction, and treatment) _____

_____

Medical Condition(s): _____

_____

Medications/Treatments: _____

_____

Does your child have any condition that could be life threating? **Check One: ☐ Yes ☐ No**

If YES , Please Explain: _____

_____

EMERCENCY MEDICAL AUTHORIZATION FORM

MEDICATION AUTHORIZATION: Dispensing Over the Counter Medication at School.

☐ **Please check if authorized to give out medication:**

Please select approved medications to give out:

☐Acetaminophen (Tylenol) 650 mg ☒Ibuprofen (Advil) 400 mg ☐Calcium Carbonate (Tums)

☐ **Please check if <u>NOT</u> authorized to give out medication**

I release and agree to hold the Board of Education its officials, and its employee harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent/Guardian **Date**

COMPLETE ONLY ONE OF THE FOLLOWING (SECTION I OR II):

SECTION I: Consent for Treatment
I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Physician **Office Phone**

_____ _____

Preferred Dentist **Office Phone**

_____ _____

Preferred Eye Specialist **Office Phone**

_____ _____

Medical Specialist **Office Phone**

_____ _____

Preferred Hospital **ER Phone**

_____ _____

Record of last Tetanus Shot _____

In the event reasonable attempts to contact me have been unsuccessful. I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

_____ _____

Signature of Parent Date

DO NOT COMPLETE SECTION II IF YOU COMPLETED SECTION I.
SECTION II: Refusal to Consent
I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment.

I wish for the school authorities to take the following actions: _____

_____

_____

****

Highland Community Learning Center Study Trip Permit

The student has my permission to participate in trips to various locations as part of the instructional/ co-curriculum activities during the school year.

Signature of Parent/Guardian _____ Date _____

EMERCENCY MEDICAL AUTHORIZATION FORM

IMMUNIZATION EXEMPTION FORM

In accordance with the Ohio Revised Code - Amended Section 3313.671 (Part A), I hereby request that

Name of Student _____

Date of Birth _____

Be exempt from school immuniztions. I understand that due to the lack of immunizations, should any epidemic or communicable disease out break occur, the above named student may be excluded from attendance at all school functions in which other students are present.

_____ _____

Signature of Parent Date

EMERCENCY MEDICAL AUTHORIZATION FORM

Highland Community Learning Center

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY HIGHLAND'S PERSONNEL

No medication that is prescribed by physician for a student shall be administered to that student unless:

1. The designated person1 receives a written request, signed by the parent, guardian, or other person having care or charge of the student, that the drug be administered to the student.
2. The signed statement that is presented to the designated person shall include the following information:

_____ _____

Name of Student Address

Is under my care and should receive _____

(Name of Drug, Dosage)

The following times _____

Specific instructions for administration (if any) _____

Common or usual side effects to watch for (if any) _____

The date the administration of the drug is to begin _____

Physician's Signature _____

Phone number where the physician can be reached if emergency _____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY HIGHLAND'S PERSONNEL

I hereby request and give my permission to the director or a delegate to administer the following medication to my child.

Name of Child _____

Name of Drug _____

Dosage _____

Administer at the following times _____

_____ _____

Signature of Parent Date

Phone number of Parent/Guardian _____