EMERGENCY MEDICAL AUTHORIZATION

I. STUDENT INFORMATION:

Name of Student:		Grade:
Birthdate:	Age:	Weight:

II. MEDICAL INFORMATION:

Family Physician:	Phone:
Specify medical allergies, chronic illnesses, asthmatic conditions, or any other special health conditions of child:	

III. MEDICATION AUTHORIZATION: (Dosage determined according to age and weight of child)

❒ Yes ❒ No	Children's chewable non-aspirin pain reliever (acetaminophen) (age appropriate dosage)
❒ Yes ❒ No	Pepto-Bismol tablets (age appropriate dosage)
❒ Yes ❒ No	Children's liquid Benedryl (age appropriate dosage)
❒ Yes ❒ No	Children's topical Benedryl gel
❒ Yes ❒ No	Cough drops (ages 5 and older)
Do you have any special instructions regarding the listed medications?	

IV. LOCAL EMERGENCY CONTACTS: (Two adults who will assume responsibility if you cannot be reached)

Name:	Relationship:	Cell Phone:
Name:	Relationship:	Cell Phone:

V. AUTHORIZATION FOR EMERGENCY TREATMENT:

As a parent and/or guardian, I authorize the treatment by a qualified and licensed medical doctor for the above named minor in the event of a medical emergency which, in the opinion of the attending physician is needed to prevent endangerment to the child's life, disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. Necessary first aid may be given at school. This release form is being completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature of Parent or Guardian _____ Date _____

Name of person filling out form _____ Relationship _____