Revised 05/2016

# LaBrae Local Schools
# Emergency Medical Authorization

**School Year** _____ **Building** _____

## Student

Last: _____ First: _____ Middle: _____ Birthdate: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Grade: _____ Primary Phone Number for Contact: _____ Parent(s) Email: _____

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

## Residential Parent or Guardian

Mother's Name: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

Father's Name: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

Other's Name: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

## Name of relative or childcare provider who will assume temporary care of your child if you cannot be reached

Name: _____ Address: _____

Relationship to child: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

Name: _____ Address: _____

Relationship to child: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

## Part I or II MUST be completed

### Part I - To Grant Consent (if refusing consent, skip Part I and complete Part II)

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

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Preferred Hospital: _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: (check all that apply)

☐ Asthma ☐ Migraine headaches ☐ Seizure disorder ☐ Other (explain) _____

☐ Diabetes ☐ Heart problems ☐ Allergies (specify) _____

Does your child have any known allergies to medications? ☐ YES ☐ NO If yes, what medication(s)? _____

Medications taken regularly: _____

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.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**If you do not wish to consent, please complete Part II and sign the second page of this form.**

Date: _____ Parent/Guardian Signature: _____

**Over**

## Part II - Refusal To Consent - Do NOT complete, if you completed Part I

I do **NOT** give my consent for emergency medical treatment of my child. In the event or illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date: _____ Parent/Guardian Signature: _____

## Grades 6-12 ONLY - MUST COMPLETE

Student Name: _____

Has permission to take the following during school if needed for headache, cramps, dental pain, pain due to minor injuries (indicate number of tablets allowed).

| | | | | |
|---|---|---|---|---|
| Acetaminophen (generic for Tylenol) | ☐ 1 tablet<br>☐ 2 tablets | Is your child allergic to acetaminophen (Tylenol)? | ☐ YES | ☐ NO |
| Ibuprofen (generic for Motrin/Advil) | ☐ 1 tablet<br>☐ 2 tablets | Is your child allergic to ibuprofen (Motrin/Advil)? | ☐ YES | ☐ NO |
| Diphenhydramine (generic for Benadryl)<br>(only for symptoms of allergic reaction: hives, swelling, etc.) | ☐ 1 tablet<br>☐ 2 tablets | Is your child allergic to diphenhydramine (Benadryl)? | ☐ YES | ☐ NO |
| Tums (for minor stomach upset) | ☐ 1 tablet<br>☐ 2 tablets | | | |

Students are permitted **2 doses per week unless there are circumstances requiring more frequent administration.** Call the school nurse to make arrangements.

Date: _____ Parent/Guardian Signature: _____