CARROLL HIGH SCHOOL

Rev (3/09)

# EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents/guardian to **AUTHORIZE EMERGENCY TREATMENT** for children who become ill or injured while under school authority, when parents cannot be reached. Reference O.R.C. 3313.712

**Please print legibly!** **(Complete both sides and return to school within 3 days)**

Student Name _____ Date of Birth _____ Grade _____

Address _____ Home Phone No. _____

The legal guardian(s) for this student is/are _____

List the names, relationship to the student, and phone numbers of those people the school should call in the event of accident or illness. This list should include the parent(s)/legal guardian(s) if they are to be contacted, and should be in the order of calling preference.

| Name: | Relationship: | Home Phone: | Work Phone: | Cell/Pager: |
|---|---|---|---|---|
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I understand that my child may be released to or given permission to drive home by anyone on the above list if he/she becomes ill or injured and must leave school.

Medical Problems/Allergies/Special Needs:

___Diabetes ___Asthma ___Seizures ___Heart ___Bee/Insect Sting ____ Orthopedic _____Other

___Visually or Hearing Impaired ___Medication or Food Allergy ___Emotional Problem ___Learning Disability

Please provide detailed information regarding any above marked areas: _____

_____

**(Use back of form if needed)**

I HEREBY GIVE CONSENT for the following medical care providers and local hospital to be called:

Doctor _____ Phone: _____

Dentist _____ Phone: _____

Medical Specialist: _____ Phone: _____

Hospital (1st choice): _____ (2nd choice): _____

PLEASE COMPLETE EITHER PART I or PART II (below):

**PART I: TO GRANT CONSENT**

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 other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

**(Use back of form if needed)**

Signature of Parent/Legal Guardian Date

**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 of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: **(MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)**

_____

_____

Signature of Parent/Legal Guardian Date

*** *** ****** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** *** ** ***

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other staff involved in the academic setting. If you do not consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school nurse.

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It is the policy of Carroll High School to send any student home who is vomiting, has a rash of unknown origin, or a temperature over 100 degrees. It is the responsibility of the parent to provide transportation for the child or to arrange for transportation.

# Carroll High School

## Request for Administration of Acetaminophen, Ibuprofen, or Antacid Tablets

***Please complete form in ink.***

**Name of Child:** _____ **Grade:** _____

**Medication Allergies** _____ Yes / No If yes, please list _____

I request and give permission for my child to have the following medication(s):

- (Initials of parent/guardian)_____One to Two tablets of Extra Strength Acetaminophen (Tylenol) 500 mg, every 4-6 hours, as needed.
- (Initials of parent/guardian)_____One to Two tablets of Ibuprofen (Advil) 200 mg, every 4-6 hours, as needed.
- (Initials of parent/guardian)_____Two tablets of chewable Antacid (Tums) as needed, but no more than 4 per day.

I do not give permission for any of the above medications to be administered by the school (Initial of parent/guardian)_____

*Acetaminophen or Ibuprofen* may be dispensed at the discretion of the School Nurse or a staff member designated by the Principal in cases such as:

* Headache
* Fever
* Toothache
* Menstrual cramps
* Common cold
* Muscular or joint pain
* Backache

*Antacid tablets* may be given at the discretion of the School Nurse or a staff member designated by the principal for complaints of heartburn or acid indigestion.

I understand that school personnel are not legally obligated to administer oral medication to my child. I also understand that persistent use of the above mentioned over-the-counter medications may require the student to have physician permission to continue the medication at school. I agree to hold the employees of Carroll High School and Beavercreek City School District free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements, which may be rendered against them.

***I will immediately notify the Carroll High School Nurse in writing should my child develop any condition, or begin taking medication which would preclude the administration of Acetaminophen, Ibuprofen, or Antacid tablets, or the need to terminate the use of this medication for any reason.***

**SCHOOL PERSONNEL will NOT administer any prescription medication unless the Prescription Medication Request Form is completely filled out with the signatures of both the physician/dentist and parent. Students with Asthma or Allergies should have an Asthma Inhaler Form and/or Epipen/Benadryl form completed by their physician and parent. Acetaminophen, Ibuprofen, or Antacid tablets will be available and can be given to the student if the parent signs this form. Students are not allowed to carry their own medication except for inhalers/epipens when the proper paperwork is completed. All medication forms can be obtained anytime throughout the year in the Main Office, Clinic or the school website.**

Signature of Parent/Guardian_____ Date_____

**Daytime phone numbers where parent can be reached:**

#1_____#2_____

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