



2009-2010 EMERGENCY CARE, OTC, MEDICAL PERMISSION FORM

PURPOSE: To enable parent/guardian to authorize emergency treatment for children who become ill or injured while under school authority when parent/guardian cannot be reached. *Both sides must be completed.*

Student Name _____ Grade _____ Age _____ Birthdate _____
Last First Middle

Address _____ Phone _____
Street City State

Mother/Guardian/Title _____ Cell Phone _____

Name of Employer _____ Business Phone _____

Father/Guardian/Title _____ Cell Phone _____

Name of Employer _____ Business Phone _____

Medical Plan/Insurance Company _____ Policy Holder _____

Policy # _____ Group # _____

List **TWO** contact people if parent/guardian cannot be reached in an emergency. They must be able to drive.

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

OVER-THE-COUNTER MEDICATION PERMISSION

DOES NOT APPLY TO EARLY CHILDHOOD STUDENTS

Over-the-counter medications approved by the consulting physician may be administered by the school nurse, or her designee, as necessary. These medications will be given according to packaging directions appropriate for weight and age.

Acetaminophen 325 mg 1-2 tablets, every 4 hours
Acetaminophen 80-160 mg 1-2 chewable tablets, every 4 hours
Motrin/Advil (children's oral suspension) 100mg/teaspoon, every 6 hours (or children's chewable)
Motrin/Advil 200mg 1-2 tablets for pain relief or dysmenorrhea, every 4 hours
Anbesol liquid for mouth pain, apply as directed
Benadryl 12.5 mg chewable tablets or 12.5 mg/teaspoon, every 6 hours
Benadryl 25-50 mg every 4 hours for allergic reaction
Benadryl gel or Caladryl lotion for insect bites
Cepacol throat lozenges
Dramamine tablets (for motion sickness, only used on school field trips)
Hydrocortisone cream ½% or 1% for rash, itching
Imodium AD according to directions for age x 1 dose
Maalox liquid antacid
Neosporin topical ointment
Halls cough drops
Robitussin DM cough syrup 1-2 teaspoons every 4 hours
Sudafed 30 mg 1-2 tablets every 4 hours
Therapeutic Mineral Ice or Icy Hot pain relieving gel
Tums antacid tablets, chew 1-2
Visine Ophthalmic drops

I **give my consent** for my child to receive the above medications at Hathaway Brown School or on school field trips, if deemed necessary by the school nurse or her designee.

I **DO NOT** want my child to receive any medication at school.

Date _____

Signature of Parent/Guardian _____

Student Name _____ Grade _____

MEDICAL PERMISSION: Complete either Part 1 or Part 2

PART 1: TO GRANT CONSENT

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

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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 doctors, 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) 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:

Date _____

Signature of Parent/Guardian _____

Do not complete Part 2 of you have completed Part 1.

PART 2: REFUSAL OF 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 the school authorities to take the following action:

Date _____

Signature of Parent/Guardian _____