DASL PHOTO

EMERGENCY MEDICAL AUTHORIZATION 2018-2019

PANDORA-GILBOA LOCAL SCHOOL

Student Name: _____ Birthdate: _____ Grade: _____

Male/Female (circle one)

Address _____ City _____

Zip Code _____ E-mail Address _____

Day Time Phone # _____ ****This number needs to have the capability to leave a message, if necessary.**

(The **ONE** number you would like to be contacted for the notification of your child's absence or other various situations.)

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.

PARENT OR GUARDIAN:

Mother's Name	Mother's Daytime Phone Number(s)	Name of Employer
Father's Name	Father's Daytime Phone Number(s)	Name of Employer
Any Other Parents/Guardians	Daytime Phone Number(s)	Relationship

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If your child becomes ill during the school day and you cannot be reached, please list persons you wish to be notified to pick your child up. Please list as many as possible.

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

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FIELD TRIP PERMISSION: _____ (student name) has my permission to go with a school chaperoned group on field trips away from the building.

Parent/Guardian Signature _____

PUBLIC RELEASE INFORMATION:

The Pandora-Gilboa School has permission to use my child's name and photograph in any school related news release to local and area newspapers, school website and to make available, upon request student directory information.

Parent/Guardian Signature _____

Other Children In Household:

Name:	Age:	Grade:	Name:	Age:	Grade:
_____	____	____	_____	____	____
_____	____	____	_____	____	____
_____	____	____	_____	____	____

Part I OR II must be completed-

Medical Conditions:

Please list or update list to include facts concerning the student's medical history including allergies, Medications/Treatments, and any physical impairments to which a physician should be alerted.

Part I—GRANT CONSENT

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

Family Physician _____ Phone # _____

Family Dentist _____ Phone # _____

Local Hospital _____ Phone # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1)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.

Date _____ Signature of Parent/Guardian _____

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Part II – 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:

_____

Date _____ Signature of Parent/Guardian _____

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Medication Authorization: (Dispensing Over-the-Counter Medications at School)

If necessary, I authorize the school nurse, principal, and/or his/her delegate to give the following over-the-counter medications as needed at his/her discretion to my child. Please check either the **YES box** or **NO box** for each medication.

Acetaminophen (Tylenol) YES ☐ NO ☐	Triple Antibiotic Cream (Neosporin) YES ☐ NO ☐
Ibuprofen (Motrin/Advil) YES ☐ NO ☐	1% Hydrocortisone Cream (for Itching) YES ☐ NO ☐
Antacid (TUMS) YES ☐ NO ☐	Cough Drops YES ☐ NO ☐
Eye Irrigation/Saline YES ☐ NO ☐	Benadryl (Allergic Reaction) YES ☐ NO ☐

(All medications will be dosed per age/weight according to package directions).

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

Date _____ Signature of Parent/Guardian _____

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