

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.

[Empty box for medical conditions]

**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 <input type="checkbox"/> NO <input type="checkbox"/>	Triple Antibiotic Cream (Neosporin) YES <input type="checkbox"/> NO <input type="checkbox"/>
Ibuprofen (Motrin/Advil) YES <input type="checkbox"/> NO <input type="checkbox"/>	1% Hydrocortisone Cream (for Itching) YES <input type="checkbox"/> NO <input type="checkbox"/>
Antacid (TUMS) YES <input type="checkbox"/> NO <input type="checkbox"/>	Cough Drops YES <input type="checkbox"/> NO <input type="checkbox"/>
Eye Irrigation/Saline YES <input type="checkbox"/> NO <input type="checkbox"/>	Benadryl (Allergic Reaction) YES <input type="checkbox"/> NO <input type="checkbox"/>

(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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