BROWN LOCAL SCHOOLS MEDICAL AUTHORIZATION

DATE_____STUDENT NAME_____GRADE_____

RESIDENCE ADDRESS_____COUNTY_____

MAILING ADDRESS_____P.O. BOX_____(IF APPLICABLE) CITY_____

STUDENT

HOME PHONE_____ DATE OF BIRTH_____

PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHILE PARENTS OR GUARDIANS CANNOT BE REACHED.

PART I OR II MUST BE COMPLETED

PART I - TO GRANT PERMISSION/CONSENT

IN THE EVENT REASONABLE ATTEMPTS TO CONTACT THE FOLLOWING HAVE BEEN UNSUCCESSFUL

	NAME	PHONE
PARENT/GUARDIAN 1.)	_____	_____
2.)	_____	_____
3.)	_____	_____
NEAREST RELATIVE, FRIEND OR GRANDPARENT		
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____

I HEREBY GIVE MY CONSENT FOR THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY:

FAMILY PHYSICIAN 1.)_____ _____
FAMILY DENTIST 1.)_____ _____

IN THE EVENT THE DESIGNATED PREFERRED PHYSICIAN IS NOT AVAILABLE, I HEREBY GIVE CONSENT FOR TREATMENT BY ANY LICENSED PHYSICIAN OR DENTIST.

I HEREBY GIVE CONSENT TO ALLOW MY CHILD TO BE TRANSFERRED BY EMERGENCY MEDICAL SERVICES TO _____OR 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 BEFORE THE SURGERY IS PERFORMED. FACTS CONCERNING THE CHILD'S MEDICAL HISTORY, INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:_____

_____

SIGNATURE OF PARENT/GUARDIAN_____

PART II - REFUSAL TO CONSENT

I DO NOT GIVE 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:_____

_____

SIGNATURE OF PARENT/GUARDIAN:_____

2014-2015 SCHOOL YEAR (PLEASE COMPLETE BACK OF THIS PAGE)

STUDENT NAME: _____

In order to help us plan for a safe and healthy school experience for your child, please check any of the following that currently apply to this student:

_____ Asthma _____ Uses inhaler _____ Does not use inhaler
_____ Bleeding disorder (hereditary coagulation disorder; anemia)
_____ Diabetes _____ Uses insulin (___ pump, ____ injection) or ____ medication by mouth
_____ Cancer, Leukemia
_____ Eating disorder, anorexia, bulimia, obesity
_____ Epilepsy or Seizure (list medication _____)
_____ Has cast, brace, supportive device, wheelchair or prosthesis
_____ Heart condition (murmur requiring medication, mitral valve prolapse or irregular beat)
_____ Life threatening allergies (anaphylaxis - requiring an EpiPen)
_____ Environmental allergies requiring medication
_____ Food allergies (list _____)
_____ Medication during the school day (explain below)
_____ Pregnancy
_____ Shunt
_____Wears hearing aid
_____ Wears glasses _____ wears contacts
_____ My child has special medical needs. Please provide medical documentation and a list of medications for the condition

Please list any prescribed medication and the condition for which medication is prescribed that your child will be taking throughout the school year.

_____
_____
_____
_____

Authorization form must be completed and on file in office before any medication can be administered at school.

YEAR 2014 - 2015