EMERGENCY MEDICAL AUTHORIZATION

LISBON EXEMPTED SCHOOL DISTRICT

☐ David Anderson Jr./Sr. High School
Grade _____

☐ McKinley Elementary School
Grade _____ Teacher _____

_____ M F
Student's Name Birth Date

_____
Address

_____
City/State/Zip

☐ CHECK IF DIFFERENT ADDRESS FROM LAST YEAR.

Please notify the school of any change in address or phone numbers during the year!

PURPOSE: *TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT AND TRANSPORTATION OF STUDENT WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY. WHEN PARENTS OR GUARDIANS CANNOT BE REACHED.*

PART I OR II MUST BE COMPLETED

PART I - GRANT CONSENT

In the event the designated preferred practitioner is not available then treatment by another licensed physician or dentist is granted. In the event that the preferred hospital is not accessible then the nearest accessible hospital is preferred. This authorization does not cover major surgery unless he medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____ _____
Signature of Parent or Guardian Address Date

In the event reasonable attempts to contact me/us:

Mother's Name or Legal Guardian	Home Phone	Work Phone	Cell, Pager, Voice Mail
Father's Name or Legal Guardian	Home Phone	Work Phone	Cell, Pager, Voice Mail
Name of closest relative & relation	Home Phone	Work Phone	Cell, Pager, Voice Mail
Name of friend/neighbor	Home Phone	Work Phone	Cell, Pager, Voice Mail

IF ALL THESE ATTEMPTS HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY:

Preferred Doctor _____ Phone _____

Preferred Dentist _____ Phone _____

Preferred Hospital _____ Phone _____

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

PART II - REFUSAL TO CONSENT

_____ _____ _____
Signature of Parent or Guardian Address Date

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 no action or to:

*** TURN PAGE OVER *** *** TURN PAGE OVER *** *** TURN PAGE OVER ***

Lisbon Exempted Village School District

Student's Name _____ Grade _____

Please complete the portions below that apply to your child.

TYLENOL PERMISSION

The Lisbon EVSD will be offering Acetaminophen (Tylenol generic) to our students who have written permission from their parents/guardians. Acetaminophen will be given for complaints of headache, mild musculoskeletal pain, or menstrual cramps, but not for an elevated temperature. In this case, the student will be sent home due to the possibility of being contagious. McKinley students will receive their dose based on age and weight. Please be award of your child requests too frequent does, I will require a written order from your child's primary physician. I hope this is a service we can offer that will help your child feel better and therefore be at their best to learn.

I give my permission for my child to receive Acetaminophen while at school. My child has no allergies or contraindications to this medication.

Parent's Signature _____ Date _____

DAHS students only

☐ 2 - 325 mg tablets (regular strength) ☐ 2 - 500 mg tablets (extra strength)

ASTHMA

If you wish for your child to have an inhaler at school for treatment of asthma symptoms, you must complete and return a **Student Medication form**. **Please contact the school nurse for a copy of this form**. This form must be completed by the parent/guardian and the student's doctor. All inhalers must be in the original container with the pharmacy label including the student's name. Check expiration dates. Students whom the doctor feels are able to use an inhaler correctly are permitted to carry it with them.

What triggers your child's asthma? How often? What seasons are worst?

_____

_____

_____

Parent's/Guardian's Signature _____ Date _____

ALLERGIES - BEES, MEDICATIONS, FOODS

If you wish for your child to have medication kept at school for treatment of a possible allergic reaction, you must complete a **Student Medication Form**. **Please contact the school nurse for a copy of this form**. This for must be completed by the parent/guardian and the student's doctor. all medications must be brought to school in the original container with the pharmacy label (if prescription). Check expiration dates.

My child is allergic to _____

Please explain your child's typical reaction: _____

_____

Parent's/Guardian's Signature _____ Date _____

School Nurse - 330-424-3215 Ext. 3008