

ST. LAWRENCE SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME _____

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.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ or _____ at _____ have been
(phone number) (other parent/guardian) (phone number)
unsuccessful, I hereby give my consent for:

1. the administration of any treatment deemed necessary by the physician and/or dentist named below 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 the hospital named below 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 prior to the performance of surgery.

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

Allergies _____
Medications _____
Other _____

NOTE: Every effort will be made to notify the parents/guardian, etc. in case of an emergency. In the event of an emergency, it would be necessary to have the following information:

Physician's Name: _____ Phone Number: _____
Dentist's Name _____ Phone Number: _____
Preferred Hospital: _____

If the parents/guardian is unavailable, other relatives or persons to contact in emergency:
Name: _____ Phone: _____ Relationship _____
Name: _____ Phone: _____ Relationship _____

Date _____ Signature of Parent/Guardian _____ Home Phone: _____
Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II REFUSAL TO 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 no action or to:

Date _____ Signature of Parent/Guardian _____
Address _____

**ST. LAWRENCE SCHOOL
AUTHORIZATION FOR ADMINISTRATION OF
OVER THE COUNTER MEDICATIONS AT SCHOOL**

Student Name

Grade

Home room

As this student's parent/guardian, I give permission for my child to receive the following medications during school hours. (Circle yes or no to all that apply.) Also, please mark if your child is allergic to any of these medications.

**Over-the-Counter Medications
Dispensed from the office**

Circle those that apply

Acetaminophen (Tylenol) for headache.	Yes	No	Allergic
Acetaminophen (Tylenol) for toothache or minor pain.	Yes	No	Allergic
Ibuprofen (Advil) for headache, toothache or minor pain	Yes	No	Allergic
Ibuprofen (Advil) for menstrual cramps	Yes	No	Allergic

**Over-the-Counter Medications
Self-Carried**

Circle those that apply

Cough Drops – (No more than 5 cough drops may be sent to school at a time. They must be in a zip-lock bag with the child's name on it.)	Yes	No	Allergic
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I give permission to the school nurse or St. Lawrence School designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the school nurse or St. Lawrence School designee from all claims as a result of any and all acts performed under this authority.

Signature of Parent/Guardian

Date

Parent/Guardian (Please Print)

How can we reach you during school hours?

Work Phone

Home Phone

Cell Phone

NOTE If your child has a chronic medical condition such a diabetes, severe allergies, migraines, asthma, etc. please have your child's physician complete and sign an individual medication consent form obtained from the school office.

If over the counter medications are given from the school office, a note will be given to the student to bring home stating the medication and time given.