ST. MICHAEL SCHOOL
2019-2020

Student Name_____Grade_____
Address_____
Home Telephone_____Birthdate_____

EMERGENCY MEDICAL AUTHORIZATION & PERMISSION TO MEDICATE

-PLEASE FILL OUT BOTH SIDES-

Residential Parent or Guardian:

In case of illness or emergency to the above named student, the school is authorized to contact individuals listed below and release the student to him/her. Please number each person 1,2,3 in order of contact.

☐ Mother's Name:_____Phone:_____(cell / home)Workplace:_____Phone:_____

☐ Father's Name:_____ Phone:_____(cell / home)Workplace:_____Phone:_____

☐ Guardian: _____Phone:_____(cell / home)Workplace:_____Phone:_____

Emergency Contact after Reasonable Attempts to Contact Parent/Guardian are Unsuccessful:

Please number each person 1,2,3 in order of contact.

	Name	Contact Type/Relation	Home Phone	Cell Phone	Work Phone
☐					
☐					
☐					

MEDICAL INFORMATION:

Medical Condition

Treatment

Allergies

Medications

PART I OR II MUST BE COMPLETED

Purpose- To enable parents/guardians the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Part 1: TO GRANT CONSENT

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

Doctor: _____Phone:_____

Dentist: _____Phone:_____

Hospital of choice: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1.) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated 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 options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained before surgery is performed.

Signature of Parent/Guardian Date

Part 2: 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 the following action:

Signature of Parent/Guardian Date

Permission to Medicate Form
2018-2019

This form serves as documentation for which over-the-counter medications/treatments may be administered to each student. You must mark yes or no for each individual medication.

As the parent/legal guardian of _____, a student at St. Michael School, I grant permission to the school nurse, secretary, principal, asst. principal and or his/her delegate to give the following medications to my child at his/her discretion:

DOSE WILL BE BASED ON WEIGHT AND AGE

Tylenol/Acetaminophen 500 mg	yes_____ no_____
Tylenol/Acetaminophen Jr. 180 mg (Equate)	yes_____ no_____
Ibuprofen/Motrin 200mg	yes_____ no_____
Ibuprofen Jr. 100mg	yes_____ no_____
Antibiotic Ointment (Neosporin)	yes_____ no_____
Benadryl gel (Itching)	yes_____ no_____
Antacid (Tums)	yes_____ no_____
Band-Aid anti itch (bug, itching ointment)	yes_____ no_____
Revive plus eye lubricant (eye drops)	yes_____ no_____
Throat/Cough Drops (Ricola)	yes_____ no_____
Canker sore topical (Zilactin B, Orajel)	yes_____ no_____
Aloe Vera gel (sun burn)	yes_____ no_____
Sunscreen	yes_____ no_____

By granting permission, I am releasing St. Michael School, nurse, principal, secretary and his/her delegate from any and all liability for civil damages arising out of or from the administration or the failure to administer the medications listed above. I further understand that this permission continues in place until I provide any written changes to the school nurse.

_____ _____
Date Parent/legal guardian signature

_____ _____
Daytime phone number Address of parent/legal guardian

Each student must have a form on file with school nurse.

8/8/2018