UNION-SCIOTO LOCAL SCHOOL DISTRICT
1565 Egypt Pike ◊ Chillicothe, OH 45601-3974 ◊ (740) 773-4102 ◊ FAX (740) 775-2852 www.unioto.org
"Today's Learners, Tomorrow's Leaders"

Emergency Medical Authorization Form

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when parent/guardian cannot be reached. Please also note all information on this form will be shared among staff to provide appropriate care of your student unless otherwise noted.

Student Information:

Student: _____Grade: _____ DOB: _____ □ Male □Female
Address: _____
Phone#:_____ Bus#:_____ Teacher/Homeroom:_____

Residential Parent/Guardian Information:

Mother:	Phone #:	Phone #:
Father:	Phone #:	Phone #:
Other:	Relationship:	Phone #:

If applicable, please list other children, grade and teacher within the district:

_____

Permission for Over-The-Counter (OTC) Medication Administration:

I give permission for my child to be given the following OTC if needed, according to school policy:

	Tylenol		Motrin		Tums		Benadryl-Oral/ Topical
	Cough Drops		Antibiotic Ointment		Calamine Lotion		Hydrocortisone Cream

Signature of Parent/Guardian: _____ Date: _____

*It is the responsibility of the parent/guardian to notify school personnel of any prior OTC medications given prior to arriving at school. By signing, this releases all school personnel of any liability related to performing this service to your child.

Other Pertinent Medical Information:

Yes, my child receives regular medical/health care for the following: □**No** medical concerns

	Seasonal Allergies		Bowel/Bladder Problems		Migraines
	Asthma, Inhaler? ☐ Yes ☐ No		Cancer		Seizures, Diastat? ☐ Ye ☐ No
	ADD/ADHD, Medicated ☐ Y ☐ No		Cystic Fibrosis		Skin Conditions
	Autism		Diabetes, Type I/II		Speech Problems
	Behavior Concerns		Depression/Anxiety		Vision/Eye Problems
	Bone/Muscle/Joint Concerns		Ear/Hearing Problems		Other:
	Blood Problems		Heart Problems		Other:

Please explain any conditions above or any reasons for hospitalizations:

_____

Is your child lactose intolerant? □ Yes □ No
Please indicate any allergies your child may have:

	Bee /Insect	Reaction:	Epi-Pen ☐ Yes ☐ No
	Food	Reaction:	Epi-Pen ☐ Yes ☐ No
	Medication	Reaction:	Epi-Pen ☐ Yes ☐ No
	Other	Reaction:	Epi-Pen ☐ Yes ☐ No

*If your child is lactose intolerant or has a food allergy, a Special Dietary Needs form must be completed to receive an alternate lunch/milk in the cafeteria. This form can be found on our school webpage.

Current prescribed medications:

Medication	Dosage	Frequency	Reason

Prescription medication required during school? □ Yes □ No

*****The Authorization for Administration of Prescription Medication form must be completed by physician and parent if your child requires prescription medication during school. All medication must be provided in the original bottle or package and will be stored in the clinic.

Does your child require any special procedures and/or treatments for their health concern? □ Yes □ No If yes, please explain:
_____
_____

Please indicate any other information about your child's health or development that you think would be helpful for the school to know:
_____
_____

Would you like to schedule a meeting with the school nurse? □ Yes □ No If yes, you will be contacted.

Emergency Treatment Part I and II:

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 the doctor listed below, or if the preferred practitioner is not available, by another licensed physician, dentist and (2) transfer my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical options of two (2) licensed physicians or dentists, concurring in the necessity of the surgery, are obtained prior to the performance of such surgery.

Part I to Grant Consent:

I hereby give consent for the following medical providers and hospital to be contacted regarding my child (this consent also includes releasing immunization records to the school):

Child's Doctor:	City:	Phone #:
Child's Dentist:	City:	Phone #:
Specialist/Medical Condition:	City:	Phone #:

Signature of Parent/Guardian: _____Date:_____

Part II Refusal to consent:

I DO NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency medical treatment, I wish the school to take the following actions:
_____
_____

Signature of Parent/Guardian: _____Date:_____

Field Trip Authorization:

I hereby give permission for my child _____ to participate in all school activities which involve field trips away from school grounds, provided such trips are an actual part of the school program.

Signature of Parent/Guardian: _____ Date: _____

Public Relations Consent:

I give my consent (or do not give consent) for audio, video, electronic images, student work, quotes, displays and photographs of my child with possible identification by full name and other personally identifiable information to be utilized by the Union-Scioto Local School District for exhibition, public display, publication, publicity materials, advertising, news media story, Internet, television, DVD and letter writing (pen-pal, thank you letters, letters to public officials, etc).

□I give my consent □I do not give my consent

Signature of Parent/Guardian: _____ Date:_____

Legal or Custody Issues:

Please list any legal or custody issues involving your child that you would like us to be aware of:
_____
_____
_____

Form Completed By:_____Signature:_____Date:_____

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Authorization for Administration of Prescription Medications to Students

This form is required in compliance with the Board of Education and our school's policy. It must be completed in its entirely and returned to the school immediately before the prescribed medication can be dispensed.

Part A: To Be Completed by Medical Provider

Name of Student: _____Grade: _____ DOB: _____
Medical Diagnosis: _____
Name of Prescription, Dosage, Route and Time of Administration at school:
_____
_____
Side Effects: _____
Is the student with asthma authorized to medicate himself/herself? □ Yes □ No
Date to start and finish medication: _____
Medical Provider's Name: _____Phone #:_____
Address: _____
Signature of Medical Provider:_____Date: _____

Part B: To Be Completed By Parent/Guardian

I request authorized school personnel to follow medical instruction requested in Part A. I understand and agree to:

1. To deliver the prescribed medication to school for my child.
2. To obtain a new authorization form for any type of change in medication, dosage, procedure and/or if the medication is to be stopped.
3. To obtain a new authorization form when there is a change in physician (even if the child is prescribed same medication).

I understand that school personnel are performing a service that is my responsibility. I release all school personnel of any liability related to performing this service, whenever reasonable cautions have been observed.

Parent/Guardian Name: _____ Phone#: _____
Signature of Parent/Guardian: _____Date:_____

Elementary	Middle School	High School
138 Sandusky Blvd.	160 Moundsville Road	14193 Pleasant Valley Road
Chillicothe, OH 45601	Chillicothe, OH 45601	Chillicothe, OH 45601
Phone #: (740) 773-4103	Phone #: (740) 773-5211	Phone #: (740) 773-4105
Fax: (740) 775-4074	Fax #: (740) 772-2974	Fax #: (740) 774-9158