



# UNION-SCIOTO LOCAL SCHOOL DISTRICT

1565 Egypt Pike ♦ Chillicothe, OH 45601-3974 ♦ (740) 773-4102 ♦ FAX (740) 775-2852 [www.unioto.org](http://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 (District will not provide OTC meds):

Parents need to provide OTC medications to the school. Dosage information is required.

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

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*It is the responsibility of the parent/guardian to notify school personnel if OTC medications have been 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	Seizures, Diastat? <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD, Medicated? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Food	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> 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

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 will learn, lead and make a difference.

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 entirety 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: \_\_\_\_\_

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

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