Authorization for Medical Treatment

Student: _____

Parent/Guardian 1: (Name and Telephone #)

_____

Parent/Guardian 2: (Name and Telephone #)

_____

Emergency Contact: (Name and Telephone #)

_____

In the event of an emergency, the following person is authorized to consent to treatment for my child. This care may include x-rays, medical or surgical diagnosis, anesthesia and hospital care for the minor at a recognized medical facility under the supervision of a licensed physician or surgeon.

School Representative: _____

Medical Insurance Company, Group # and ID #

_____

_____

AUTHORIZATION TO SELF-CARRY/ADMINISTER MEDICINE

FOR SCHOOL DAY, SCHOOL TRIPS AND EXTRACURRICULAR SCHOOL ACTIVITIES

Little Silver Board of Education policy permits a responsible, trained student to carry and self-administer medication for asthma, anaphylaxis and diabetes for immediate use in a life threatening situation with written order of physician, parent request, principal and school nurse approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Student Name:_____

Condition:_____

Medication, Dosage and Time: _____

Duration of administration:_____

IT IS MY OPINION THAT THIS STUDENT CAN RESPONSIBLY SELF-CARRY AND ADMINISTER THIS MEDICATION.

Physician Signature:_____ **Date:**_____

Print Name or Stamp: **Telephone:**_____

PARENT/GUARDIAN AUTHORIZATION

I request that my child be permitted to carry and self-administer the above ordered medication. I understand that the medication must be in the original container.

Parent Signature:_____ **Telephone:**_____

Student Signature:_____

We accept the request. We will permit and assist the student to be responsible. We reserve the right to withdraw permission if the student shows signs of irresponsible behavior or there is a safety risk.

School Nurse Signature:_____

Principal Signature: _____

MARKHAM PLACE SCHOOL

HEALTH AND MEDICAL FORM FOR SCHOOL TRIPS

Medical Information

All forms and medications must be received by May 25th, 2018 in the Nurse's office

Current Health Conditions: (attach health care plan for each condition)

1)

2)

3)

Medications taken: (indication, schedule and dosage)

1)

2)

3)

4)

5)

Self-administration: (please attach physician's from for self-administration of medicine)

1)

2)

Allergies: (medication and dosage)

1)

2)

3)