SHEKINAH CHRISTIAN SCHOOL
10040 LAFAYETI'E P.C. RD.
PLAIN CITY, **OH 43064**
614-873-3130

EMERGENCY MEDICAL AUTHORIZATION

Parents:_____Address:_____

Phone Numbers to be reached at:_____

Students Names:_____

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 and returned.

PART I (TO GRANT CONSENT)

In the event that I cannot be reached at home_____ or at work _____
(Phone at home) (Phone at work)

I give my consent to have

Dr. _____
(Physician) (City) (Phone)

or Dr. _____
(Dentist) (City) (Phone)

administer any treatment deemed necessary. **If** the doctor of my choice cannot be reached I give permission to have another licensed physician or dentist attend my child.

If emergency room services or admission to a hospital is necessary, I prefer

_____,but give permission to services of
(Hospital) (City)
hospital which may be closer.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring to the necessity for such surgery are obtained prior to the performance of such surgery.

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

_____

_____

_____ _____
Date of Signature Parent or Guardian

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 of Signature Parent or Guardian

Medical Action Information

Student(s):_____

We hereby give permission for **SHEKINAH CHRISTIAN SCHOOL** to administer the following medication to our children:

[ ] Acetaminophen non-aspirin pain pills (Tylenol)

[ ] Ibuprofen pain pills (Advil)

[ ] Antacids (Tums)

[ ] Cough Drops

[ ] No pain pills [ ] No Antacids (Tums) [ ] No Cough Drops

Signature of Parent: _____ Date _____

In the event of an emergency, or illness and we cannot be reached, please contact:

1. _____ Phone _____

2. _____ Phone _____

If your student uses an inhaler or has food, animal, or environmental allergies, we need to know what plan of action we should take with them at school. (There is an asthma form with the school nurse that will need filled out by your Dr.)

My student(s):_____ uses an inhaler.
Name(s)

Please tell us how your child uses the inhaler, the dosage and frequency, and what action we should take if the treatment is ineffective.

_____

_____

My student(s):_____is allergic to the following:
Name(s)

_____

Please tell us what symptoms we might see with your student and how they should be treated.

_____

_____

Signature:_____