BRIGHT LOCAL SCHOOLS EMERGENCY MEDICAL FORM

Student Name: _____

Address: _____

Mailing Address (if different from above):_____

City: _____ State: ___ Zip _____

Home Phone Number_____ Date of Birth_____

E-Mail Address: _____

Teacher: _____
Grade _____
Bus Driver: _____

Names and grades of school age brothers and sisters_____
_____
_____

In the event of illness or injury of the above named child, the following people may be contacted to arrange for care or authorize emergency treatment. (Include cell phone numbers. Notify the school if any of this information changes.)

Mother
Name: _____Daytime Phone: _____

Address: _____

Father
Name: _____ Daytime Phone: _____

Address: _____

Babysitter or Childcare Provider:
Name: _____ Daytime Phone: _____

Address: _____

Other Authorized Friend or Relative:
Name: _____ Daytime Phone: _____

Address: _____

Part I: To Grant Consent

In the event that reasonable attempts to contact me have been unsuccessful, I hereby grant my consent for 1) the following medical personnel or facilities to administer treatment deemed necessary by the named persons, or in the event that the preferred individual is not available or the designated facility is not readily accessible, permission to treat is extended to other licensed physicians, dentists, or medical care facilities; and 2) the transport of the child to any hospital reasonably accessible.
The authorization does not extend to major surgery, unless the medical opinions of two licensed physicians or dentists concur, prior to such surgery, that the surgery is both necessary and urgent.

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Hospital: _____ E. R. Phone: _____
Medications, Medical Conditions, Allergies or other Pertinent Medical Information:
_____

Part II: ONLY TO REFUSE CONSENT

I DO NOT give permission for medical treatment. In the event of a serious injury or illness requiring emergency treatment please do the following:_____
Parent Signature_____ Date_____

Bright Local School District
Permission to Administer Medication

Student Name: _____ Grade:_____ School Year:_____

Birthdate: _____ Age: _____ Allergies to Medication? _____Yes _____No

If yes, please list _____Epi-Pen? _____ Asthma? _____

Over the Counter Medications

Over the counter medications will be administered sparingly when indicated to make your child more comfortable and able to remain at school. Dosage will be administered according to your child's weight/age. Amount and frequency will be strictly adhered to according to the manufacturer's label. I give permission for the school to administer the following medications (check all that apply):

____I do not wish for any over the counter medications to be administered at school.

____**Diphenhydramine HCL** (Generic for Benadryl) – Liquid, capsule or tablet form. Given for allergic reaction, hives, itching rash, sneezing, or other allergy symptoms.

____**Hydrocortisone Cream** (0.5%-1% Anti-itch cream) Given for skin rash, itching, redness, hives, or skin irritation.

____**Medicaine Swabs** (Benzocaine 20%, L-Menthol 1%) Given for insect bites or bee stings.

The medications listed above are the **only** medications that are kept in the clinic/office at school. Al other medications your child may need during school hours must be brought in by the parent/guardian.

In signing this form, I acknowledge that I give permission for the above, over the counter medications, to be administered to my child as indicated; I further acknowledge that I release Bright Local School District and its staff members/employees from any liability of any nature that might result from the proper administration of medication to my child.

***If a student requests the same medication three consecutive days, a phone call will be placed to the parent/guardian before any further medication is given. If a student requires any of these medications for more than three consecutive days, or if your child requires frequent use of any of these medications throughout the school year, please bring in a new, unopened box, labeled with the child's name and completed Non-Prescription Medication Form (available on the district website and in the office).**

Signature of Parent or Guardian: _____Date_____