2017-2018
SOUTHEAST DUBOIS SCHOOL CORPORATION
EMERGENCY AND MEDICAL CONSENT

The undersigned parent or legal guardian of_____ does hereby grant and authorize the Southeast Dubois County School Corporation and any employee thereof, to obtain at the expense of the undersigned, any medical services, including but not limited to X-ray examination, anesthetic, surgical treatment, or any hospital service for the above named student in the event said student suffers any illness or accident at a time when the undersigned cannot be contacted. It is my request that such treatment shall be rendered by our family doctor_____ or physician "on call" at the hospital emergency room.

Date: _____Parent or Guardian: _____

Doctor: _____ Dentist: _____

Drug Allergies: _____ Other Allergies: _____

Daily Prescription Medication: _____

Reason for Medication: _____

Does the student wear glasses/contact lenses? Yes____ No ____Does the student have any of the following conditions? Asthma: Yes _____ No _____

ADD/ADHD: Yes _____ No _____ Diabetes- Type I: Yes _____ No _____ Type II: Yes _____ No _____

Special medical instructions: _____

_____

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AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

Parent or Guardian:

The following information is necessary for any student to receive non-prescribed medications in school. **ALL SPACES MUST BE COMPLETED.**

_____ _____
Name of Student Grade

A. Clinic Medications may include the following. Please **checkmark** any/all medications you would allow your child to be given, then fill in the dosage and frequency:

MEDICATION	DOSAGE	MAY REPEAT HOW OFTEN?
Tylenol		
_____ Adult tablets	_____	_____
_____ Children's liquid	_____	_____
_____ Children's chewable	_____	_____
_____ Jr. strength chewable	_____	_____
Advil		
_____Adult tablets	_____	_____
_____ Children's liquid	_____	_____
Benadryl		
_____ Adult capsule	_____	_____
_____ Liquid	_____	_____
Tums _____	_____	_____

For grades K-4 only:
I would like to be called every time my child receives medication at school.
Yes____ No____

B. I will assume responsibility for safe delivery of the medication to school. **An adult must bring any/all medications to and from school. Do not send any medication with the student.**
C. I will notify the school immediately if there is any change in the use of the medication or prescribed treatment.
D. Our physician has instructed that this medication should be administered in the above dosage.
E. I realize that no non-prescribed medication will be given before 10:00 am.
F. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Home Telephone Number **Work Telephone Number**