THE RATNER SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: TO ENABLE PARENTS OR 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.

CHILD'S NAME _____

ADDRESS _____ TELEPHONE _____

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Guardian1 Name _____ Daytime Phone _____

Parent/Guardian2 Name _____ Daytime Phone _____

Emergency Contact 1 Name _____ Daytime Phone _____
Relationship to Child: _____

Emergency Contact 2 Name _____ Daytime Phone _____
Relationship to Child: _____

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in 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:_____

PLEASE PROVIDE A COPY OF INSURANCE CARD/INFORMATION WITH THIS FORM.

Date _____ Signature of Parent/Guardian _____

I UNDERSTAND THAT RATNER SCHOOL WILL NOT BE RESPONSIBLE FOR MEDICAL EXPENSES INCURRED, BUT THAT SUCH EXPENSES WILL BE MY REPONSIBILITY AS PARENT/GUARDIAN _____ *(Parent/Guardian Initials)*

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 the following action:

_____

Date _____ Signature of Parent/Guardian _____

THE RATNER SCHOOL - EMERGENCY TRANSPORTATION AUTHORIZATION

STUDENT'S NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____

BIRTHDATE_____/_____/_____ **GENDER** _____

LIST TWO LOCAL PEOPLE WHO CAN BE CONTACTED AND TAKE RESPONSIBILITY FOR YOUR CHILD IN AN EMERGENCY IF THE PARENTS CANNOT BE REACHED:

NAME _____**RELATIONSHIP TO CHILD** _____ **PHONE NO.** _____

ADDRESS _____

CITY, STATE, ZIP _____

NAME _____ **RELATIONSHIP TO CHILD** _____ **PHONE NO.** _____

ADDRESS _____

CITY, STATE, ZIP _____

PHYSICIAN'S NAME _____ **PHONE NO.** _____

ADDRESS _____

CITY, STATE ,ZIP _____

DENTIST'S NAME _____ **PHONE NO.** _____

ADDRESS _____

CITY, STATE, ZIP _____

TO GRANT CONSENT

THE FOLLOWING SECTION ONLY AUTHORIZES THE CHILD CARE FACILITY TO SECURE EMERGENCY TRANSPORTATION FOR A CHILD. THIS FORM DOES NOT AUTHORIZE OR GUARANTEE TREATMENT UPON ARRIVAL AT THE DESIGNATED SOURCE OF EMERGENCY MEDICAL OR DENTAL TREATMENT, AS EACH EMERGENCY FACILITY SETS ITS OWN TREATMENT PROCEDURES.

I GIVE MY PERMISSION TO THE RATNER SCHOOL TO TRANSPORT MY CHILD TO THE FOLLOWING EMERGENCY FACILITIES FOR EMERGENCY MEDICAL OR DENTAL CARE, OR TO THE NEAREST AVAILABLE SOURCE OF ASSISTANCE.

PREFERRED HOSPITAL OR CLINIC _____

PREFERRED DENTIST OR DENTAL CLINIC _____

_____

Signature of parent or guardian to grant consent **Date**

I UNDERSTAND THAT RATNER SCHOOL WILL NOT BE RESPONSIBLE FOR MEDICAL EXPENSES INCURRED, BUT THAT SUCH EXPENSES WILL BE MY REPONSIBILITY AS PARENT/GUARDIAN _____ **(Parent/Guardian Initials)**

REFUSAL TO CONSENT

I DO NOT GIVE PERMISSION TO THE RATNER SCHOOL TO TRANSPORT MY CHILD FOR EMERGENCY MEDICAL OR DENTAL CARE. IN THE EVENT OF AN ILLNESS OR INJURY WHICH REQUIRES EMERGENCY MEDICAL OR DENTAL TREATMENT, I WISH THE FOLLOWING ACTION TO BE TAKEN:

_____

_____

_____

Signature of parent or guardian to refuse consent **Date**

The Lillian and Betty
Ratner School

WHERE EACH CHILD THRIVES

AUTHORIZATION FORM
SELF-MEDICATION
FOR ASTHMA INHALERS

Student Name: _____ Date of Birth: _____

Address: _____

TO BE COMPLETED BY PHYSICIAN

Medication Name: _____ Dosage: _____

Frequency: _____

Start Date: _____ Stop Date: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

_____

Other special instructions: _____

PHYSICIAN AND PARENT/GUARDIAN SIGNATURES AND EMERGENCY PHONE NUMBERS

Physician's Name: _____ Phone: _____

Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:
I give permission for my child _____ to self-medicate with his/her asthma inhaler at school according to school policy as instructed by the physician and agree to the following:

* to deliver medication to school in the original container,
* to have a new form completed by the physician if medication or dosage is changed or discontinued,
* to notify the school if we change physicians,
* to grant immunity to The Lillian and Betty Ratner School and its employees for good faith actions in connection with this permission,
* to have my child report to and notify school personnel when the inhaler is used.

Parent's/Guardian's Signature: _____ Date: _____

Day Phone Numbers: _____

The Lillian and Betty
Ratner School

WHERE EACH CHILD THRIVES

MEDICATION PERMISSION FORM

Student: _____ Grade: _____ Date of Birth: _____

Address: _____ Phone: _____

TO BE COMPLETED BY PHYSICIAN

Date: _____ Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment:

❑ tablet/capsule ❑ liquid ❑ inhaler ❑ injection ❑ nebulizer ❑ other

Instructions:
Dose: _____ Frequency:_____ Time(s) to Administer:_____

Start Date: _____ Stop Date:_____

Side Effects: _____

Restrictions: _____

Special Storage Instructions: _____

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____ **Phone:** _____

Physician's Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I GIVE PERMISSION FOR MY CHILD_____TO RECEIVE MEDICATION AT SCHOOL ACCORDING TO SCHOOL POLICY AS INSTRUCTED BY THE PHYSICIAN AND AGREE TO THE FOLLOWING:

❑ **to deliver medication to school in the original container.**
❑ **to have a new form completed by the physician if medication or dosage is changed or discontinued.**
❑ **to notify the school if we change physicians.**

Parent's/Guardian's Signature: _____ Date:_____

The Lillian and Betty Ratner School
27575 Shaker Boulevard | Pepper Pike, OH 44124
telephone 216.464.0033 facsimile 216.464.0031 website www.theratnerschool.org

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

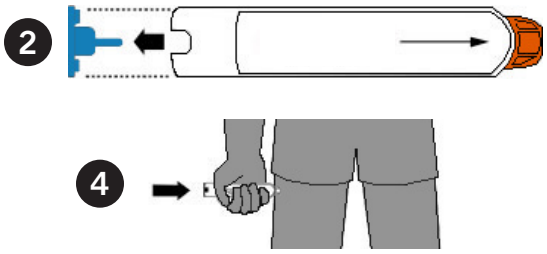
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

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