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

**EMERGENCY MEDICAL AUTHORIZATION FORM**

Last Name_____
Student Name(s)_____
Address _____
Telephone Number _____

**Emergency Contact Information**

Mother's Name: _____ Daytime Phone Number: _____

Father's Name: _____ Daytime Phone Number: _____

Relative or Childcare Provider: _____ Relationship: _____

Address: _____ Phone Number: _____

**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)**

I hereby give my consent to have the below medical care providers and local hospital to be called.

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

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

or Dr. _____
(Medical Specialist) (City) (Phone)

If emergency room services or admission to a hospital is necessary, I prefer the below hospital but give permission to services of any hospital that is reasonably accessible.

_____
(Hospital) (City)

In the event reasonable attempts to contact an emergency contact listed above are 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 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 Signature

**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 of Signature Parent or Guardian Signature

**MEDICAL ACTION INFORMATION**

**Student(s):_____** I 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)

[ ] Antihistamine (Benadryl)

[ ] Antacids (Tums)

[ ] Cough Drops

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

Signature of Parent: _____ Date _____

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. Additionally, there is an asthma form with the school nurse that will need filled out by you and your physician.

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. Additionally, you will be required to provide us with an Authorization for Student Possession and Use of an Asthma Inhaler completed by you and your child's physician.

_____

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: _____