THE FAMILY CENTER

Emergency Information and Parent Consent Form

Student: _____ Date: _____
(Last) (First) (MI)

Date of Birth: _____/_____/_____

PRIMARY HOUSEHOLD

Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Parent/Guardian: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Parent/Guardian: _____
Work Phone: _____
Cell Phone: _____
Email: _____

SECONDARY HOUSEHOLD

Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Parent/Guardian: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Parent/Guardian: _____
Work Phone: _____
Cell Phone: _____
Email: _____

DESIGNATED EMERGENCY CONTACT AND RELEASE

Name: _____
Relationship to student: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____
Relationship to student: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

I give permission for the school to contact and/or release my child to the above person(s) in the event that a parent/guardian cannot be reached.

_____
Signature of Parent/Guardian Date Please Print Name

MEDICAL INFORMATION

Student's Physician: _____ Phone: _____ Hospital:_____

Student's Dentist: _____ Phone: _____

Is your child on any medication? No Yes If yes, please specify: _____

_____

Does your child have any food or drug allergies? No Yes If yes, please specify: _____

_____

(Please fill out reverse side.)

The School District of Clayton, in collaboration with the District's consulting physician, have agreed to the administration of certain over-the-counter (OTC) medications according to the physician's standing order. Listed below are the OTC medications that, based on professional nursing assessment and judgment, may be administered to students who have parental permission (see "CONSENT" below). This medication may be administered by the nurse or authorized designee. Our goal is to promote health and wellness in the school setting.

ORAL (Parents will be contacted prior to oral medications ONLY)

- Diphenhydramine (Benadryl)
- Ibuprofen (Advil)
- Acetaminophen (Tylenol)
- Loratidine (Claritin)

EYES/OCULAR

- Saline solution or equivalent

TOPICALS

- Bacitracin/polysporin
- Vaseline
- A&D Ointment
- BZK antiseptic wipes
- Caladryl or calamine
- Aloe vera gel or solarcaine spray
- Hydrogen peroxide

Please provide any other significant information that would help us meet the health needs of your child:

_____

_____

Consent

Parental approval to use standing physician-ordered medications allows for efficient treatment of students' minor health issues and their prompt return to the classroom setting.

_____
Parent initial
to give consent.

I give my permission for the nurse or trained designee to administer appropriate standing physician-ordered medications (listed above) for my child's minor illness, injuries or complaints of discomfort according to the package indications and dosing instructions

Notice of Agreement

To ensure the safe care of my child, I agree that pertinent health information may be shared with appropriate school staff on a need-to-know basis. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and addresses in case of emergency. The school nurse may contact the health care provider regarding any health concerns pertaining to students.

I understand that basic first aid and emergency care will be provided as needed by school staff.

I understand that in an emergency my child will be transported by ambulance. I authorize emergency personnel to carry out diagnostic and emergency care as deemed necessary. I understand the cost of the ambulance and medical care are my responsibility.

I acknowledge that the foregoing above information is true and correct.

Signature of Parent/Guardian:_____ Date: _____