EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT 2017-2018

(To be completed by parent-One per family)

_____

Family Name

Student's first & last name:

1. _____/Grade: _____, 4. _____/Grade: _____

2._____/Grade: _____, 5. _____/Grade: _____

3.:_____/Grade:_____, 6. _____/Grade: _____

Students live with:☐Both Parents ☐Mother ☐Father, Legal custody___ Mom___ Dad___ Joint

Dad:_____ Address: _____Telephone(____)_____
Place of Employment: _____ Occupation:_____
Work #(___) _____ Cell Phone #: (____)_____
Beeper #: (____)_____

Mom: _____ Address:_____ Telephone:(___)_____
Place of Employment: _____ Occupation: _____
Work #: (___)_____ Cell Phone #: (___)_____
Beeper #: (___)_____

Step-Dad:_____ Address:_____ Telephone:(___)_____
Place of Employment: _____ Occupation:_____
Work #: (___)_____ Cell Phone #: (___)_____
Beeper #: (___)_____

Step-Mom:_____ Address:_____ Telephone(___)_____
Place of Employment: _____ Occupation: _____
Work #(___)_____ Cell Phone #:(___)_____
Beeper :(___)_____

IN CASE OF AN EMERGENCY AND A PARENT CANNOT BE REACHED, THE FOLLOWING *LOCAL* PEOPLE CAN BE CONTACTED TO RESPOND IN THE PARENT'S ABSENCE.

Name	Phone	Relationship
1.	H: _____ W: _____ C: _____	
2.	H: _____ W: _____ C: _____	
3.	H: _____ W: _____ C:_____	

_____
Name of Physician and Phone #

_____/_____
Name of Dentist and Phone # Name of Orthodontist and Phone #

OVER PLEASE 

CONSENT TO ADMINISTER MEDICATION

School personnel must have parental consent to dispense **over the counter** medications. Be it understood that any school employee who administers any drug to my child(ren) in accordance with written instructions shall not be liable for damages as a result of an adverse reaction suffered by my child(ren) because of the administering such drug. I hereby authorize the school nurse or persons designated to administer medication in her absence, to administer the following medications (OTC) and/or prescriptions. All medication will be maintained in the nurses' office and dispensed according to label instructions and at the discretion of the school nurse. All prescription medications **MUST** be brought in their original pharmacy container and appropriately labeled. If it is necessary for the student to retain possession of medications (i.e. inhalers), this must be discussed with the school nurse, requested in writing via this form and approved by your child's physician.

I hereby give permission for _____ to be administered the following:

Name of student(s)

Non-Prescription:

☐ You may give my child(ren) "over the counter" medications.

YES, my child(ren) is/are allergic to medications? Please list them:

_____

☐ I do not want my child taking any medications at school

I further understand that any school employee who administers any prescription or "over the counter" drug in accordance with written instructions from a physician, dentist, or parent shall **not** be liable for damages as a result of an adverse drug reaction suffered by a student because of administering such a drug. I hereby authorize the school nurse or person designated to administer medication in her absence, to administer the following medications (OTC) and or prescriptions. All medications will be maintained in the nurse's office and dispensed according to label instructions and at the discretion of the school nurse.

If your child(ren) should become seriously ill or injured at school and you or your physician cannot be reached within a reasonable length of time, may a staff member of St. Ann's Catholic School have permission to take appropriate action to see that your child gets emergency hospital care via ambulance? ☐ **YES** ☐ **NO**

You have permission to transport my child(ren) by bus or other means to take part in field trips, concerts or any event sponsored by the school. ☐ **YES** ☐ **NO**

I, the undersigned, do hereby authorize officials of St. Ann School to contact directly the persons named in this sheet, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the said child(ren).

In the event physicians, other persons named in this sheet, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in this judgement, for the health of the aforesaid child(ren).

I will not hold the school district financially responsible for the emergency care and or transportation for the said child(ren)

Statement of Consent:
In order to better serve the health needs of my child, I hereby give permission for the transfer of health history, immunization record to the Kansas Immunization Program and screening records to the teachers, staff and other health professionals that deal with my child(ren) at St. Ann School. I acknowledge this will keep all staff members informed of any changes in my child's health. I authorize school personnel to obtain emergency medical care for my child in the event I can not be reached. In addition, all of the information provided on this form is accurate to the best of my knowledge. I have been given a copy of my FERPA (rights to privacy) that is in the school calendar for this school year 2017-18.

_____

Signature of Parent or Guardian **Date**