**2015-2016**

**Emergency Medical Form (*Due at Registration*)**

Chaminade Julienne Catholic High School505 S. Ludlow St. Dayton, OH 45402

Clinic phone: (937) 461-3740 ext 227, Fax: (937) 461-6091

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: 9 10 11 12**

**Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1st Contact 2nd Contact**

**Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Part I-Consent to treat**: In the event a parent/guardian cannot be reached, list 2 people we may contact who can act on behalf of the parent:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unsuccessful in contacting the above parties, I hereby give my consent for administration of treatment deemed necessary by:

Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event the designate practitioner or preferred dentist is not available, I give consent for treatment by another licensed physician or dentist. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**Pertinent medical history and current information the school or emergency personnel should be aware of including allergies, medication taken at home or school, any physical impairment, etc are as follows**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last tetanus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition requires medication at school: Yes \_\_\_\_\_\_ No\_\_\_\_\_\_ Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition requires a health plan to be shared with teachers: Yes \_\_\_\_\_ No \_\_\_\_\_

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Part II REFUSAL to CONSENT (*Do not complete if completed Part I above*)**

I ***do not*** give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take no action, or:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

***~COMPLETE BOTH SIDES~***

**2015-2016**

**Request for Administration of: Acetaminophen, Ibuprofen, and/or**

**Calcium Carbonate (Antacid)**

Chaminade Julienne Catholic High School

505 S. Ludlow St. Dayton, OH 45402

Clinic phone: (937) 461-3740 ext 227, Fax: (937) 461-6091

**Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_ Gender:\_\_\_\_**

I request oral administration of the following medication(s) for my child:

**\_\_\_\_ (*Initials* of parent/guardian)** Two tablets of Extra Strength Acetaminophen (500 mg

each tablet), every 4-6 hours, as needed.

\_\_\_\_\_ **(*Initials* of parent/guardian)** Two tablets of Ibuprofen (200 mg each tablet), every

4-6 hours, as needed.

\_\_\_\_\_ **(*Initials* of parent/guardian)** One to two extra strength chewable antacid tablets

(750mg calcium carbonate each tablet)as needed.

Acetaminophen or Ibuprofen may be dispensed at the discretion of the school nurse or proxy in cases such as:

• headache

• the common cold

• fever

• muscular aches

• toothache

• backache

• menstrual cramps

Calcium carbonate may be dispensed at the discretion of the school nurse or proxy in cases such as:

• stomach ache

• acid indigestion/heartburn

I understand that the school personnel are not legally obligated to administer oral medication to my child. I agree to hold the employees of Chaminade Julienne Catholic HS and Public Health-Dayton and Montgomery County, free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. ***I* *will immediately notify CJ in writing should my child develop any condition, or take any medication, which would preclude the administration of Acetaminophen or Ibuprofen, or to terminate the use of this medication for any reason.***

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_

Daytime phone number where I can be reached: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***~COMPLETE BOTH SIDES~***