Chatfield Public Schools I.S.D #227
Chatfield, MN

FAX NUMBERS:
High School: 507.867.3147
Elementary: 507.867.4525

CONSENT FORM FOR EMERGENCY INJECTIONS
(TO BE RENEWED ANNUALLY)

Student:_____________________________________ Date of Birth____________
Parent/Guardian:____
School____________________________Teacher/grade:_______________________

We, the undersigned parent(s)/guardian(s) of the above-named child, acknowledge that we have read and received a copy of the Chatfield Public Schools' policy for administering medications in school. We understand that medically trained personnel are not available in a school at all times and that normally school personnel and school nurses are not allowed to administer medication unless prescribed by a physician.

We are now requesting that the persons named below be allowed, in an emergency, to administer medication by injection to our child:_________________ as prescribed by our physician:______________________________, for the emergency treatment of ________________________(condition). We understand that this medication is given by an injection, and that as with any injection there are risks involved. We feel that the danger of delay in treatment of our child outweighs these risks and request the use of this medication despite the risks involved.

If these persons are allowed to administer the medication described, we state that they are not liable to us or our child for any injury, illness, death or disability caused by administering, providing, or injecting the prescribed medication and we hereby specifically release and hold harmless these persons, their supervisors and I.S.D. 227 from any liability resulting from the administration or non-administration of the medication.

We also direct that Dr.______________ furnish to the I.S.D 227 information regarding the administration of this medication and any further information regarding the health of the child that may be necessary. We acknowledge that we have been given a copy of such information.

The following persons are authorized to administer the medication mentioned above:

Name	Position
1.	
2.	
3.	
4.	
5.	

Parent(s)/Guardian(s):
1.________________________________ Date: _________
2.________________________________ Date: _________

When there is reasonable evidence that the above-named person has been exposed to the offending allergen. I prescribe the immediate injection of:_______________________ to be given by school personnel.

Physician's signature:________________________________ Date:________________
Print Physician's Name: ______________________________