Please complete both pages, print as a 2-sided copy, and sign.

River View Local School District

Please Choose School Year

EMERGENCY MEDICAL AUTHORIZATION

PLEASE PRINT USING BLUE OR BLACK INK

Please Choose School Attending	Student's Name	Grade:
/ A.M. Bus#/Driver's Name	Student's Street Address / City	Date of Birth: / /
/ P.M. Bus #/Driver's Name	Home Phone / Student's Cell Phone (if applicable)	Home Email Address (if applicable)

Purpose: The purpose of this form is 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 Part II must be completed

PART I To Grant Consent

Mother's Name	Home Phone	Cell Phone	/ Place of Employment/Work Phone
Father's Name	Home Phone	Cell Phone	/ Place of Employment/Work Phone
Stepparent's Name (if applicable)	Home Phone	Cell Phone	/ Place of Employment/Work Phone
/ Relative Name / Relationship	Home Phone	Cell Phone	/ Place of Employment/Work Phone

In the event reasonable attempts to contact any of the above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Preferred Physician	Office Phone	City
Preferred Dentist	Office Phone	City

Or in the event the designated preferred practitioner is not available the child will be transported to the nearest medical facility. This authorization does not cover major surgery unless the medical options of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history include allergies, medication being taken, and any physical impairments to which a physician should be alerted to are: (List or check "NONE")

☐ Check if "NONE" or list here. _____

SIGN HERE & ON PAGE 2

_____ / _____ _____ / _____ / _____

Signature of Parent or Guardian **Relationship** **Date**

_____ _____ _____

Street address **City** **Zip**

(Do not complete part II if you completed part I)

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 no action or to:

_____

_____ _____ / _____ / _____

Signature of Parent or Guardian Date

Please complete both pages, print as a 2-sided copy, and sign.
Your completed form can be saved!

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River View Local School District
Telephone Calling Order/Health Information

Student's Name	Grade	Teacher / Homeroom	**Please Choose** School

During the course of the school year there are times when a student may need to leave school due to illness requiring transportation home. Parents or guardians may not be available during these times. Students who are ill must be dismissed to a responsible adult. Please list below the names of three adults *(including yourself as parent/guardian)* who you would prefer for us to call in case of illness or emergency. Please put these names *in the order of who should be called first*, second, etc. Please notify the school when telephone numbers or contact information changes.

Call	Name	Relationship	Primary Phone #	Alternate / Work Phone #
1st				
2nd				
3rd				

In order to help us plan for a safe and healthy school experience for your child, please check any of the following that currently apply to this student and *explain in the space provided*. If no problems, check the two ** statements below.

SIGN HERE & ON FRONT

- ☐ Activity Restrictions (list in box below)
- ☐ Asthma (list treatment below, including inhaler use)
  (Medical form MUST be completed for student to have an inhaler at school or at school functions.)
- ☐ Allergies - Environmental/Seasonal
- ☐ Allergy to Medications (list in box below)
- ☐ Allergy to Food that is *LIFE THREATENING*
  (List food & treatment below & have med forms completed)
- ☐ Allergy to Bees/Insects that is *LIFE-THREATENING*
  (List insect & treatment below & have med forms completed)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart condition (explain)
- ☐ Medication taken daily at home (list in box below)
- ☐ Medication during the school day (list in box below)
- ☐ Menstrual problems/severe pain
- ☐ Mental health concerns/depression
- ☐ Nosebleeds (frequent)
- ☐ OTHER: Please explain in box below.

☐ My child has special health care needs. Please have the school nurse contact me to develop a school based health plan.
(If this needs addressed immediately, please call the school nurse ASAP)

☐ ***MY CHILD HAS NO KNOWN MEDICAL OR HEALTH CONDITIONS.***

☐ ***MY CHILD HAS NO ACTIVITY RESTRICTIONS AT SCHOOL AND CAN PARTICIPATE FULLY IN ALL PHYSICAL ACTIVITIES.***

Parent/guardian signature _____ Date _____

◉ Yes ○ No I give permission to share this health information with school staff as needed.

**** GRADES 7-12 ONLY ****

(Grades PS-6 require physician authorization for *ALL* medications)
OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION

If your child may need pain medication during the school day, please complete this section that authorizes the school to administer either ibuprofen or generic Tylenol® as needed.
If an over-the-counter medication, other than the two listed, is preferred please complete the "Over-the-Counter" form available on the RV Website or in the JH or HS office and supply the preferred medication.

I hereby request and give my permission to the principal, or designated school personnel, to administer the following medication to my child. (Check ALL that apply.) I acknowledge that my child has taken this medication previously and had no adverse reaction to it.

- ☐ Ibuprofen 200 - 400 mg every 4 hours as needed
- ☐ Generic Tylenol® 500 - 1000 mg every 4 hours as needed

Parent/Guardian signature _____ Date _____

ALL medications MUST be kept in the school clinic. Students ARE NOT permitted to carry medications with them at school or at school functions.

List any additional information concerning your child's health or medical conditions of which school staff should be aware.
List medications taken, allergies, and treatments here.

Please complete both pages, print as a 2-sided copy, and sign.
Your completed form can be saved!