

Prescott Unified School District #1

EMERGENCY MEDICAL CONSENT FORM

This form covers the time period for the grade enrolled below, and it is required to be submitted for your student to receive over-the-counter medications in the nurse's office.

Student's Last Name **Student's First Name** **Date of Birth** **Grade Enrolling**

Parent/Guardian Name _____

Mailing Address _____

Home Address _____

City and Zip Code _____

Contact (1) _____ Relationship _____ Phone _____

Contact (2) _____ Relationship _____ Phone _____

EMERGENCY CONTACTS

Who can care for/pick up your child if you are not available (someone other than a parent/guardian).

Name (1) _____ Relationship _____ Phone _____

Name (2) _____ Relationship _____ Phone _____

Name (3) _____ Relationship _____ Phone _____

The undersigned parent/guardian, having legal custody or control of a minor, GRANTS PERMISSION for any emergency treatment and hospital services that may be rendered to said minor under the general or specific direction of Dr. _____ or any hospital emergency department physician.

Parent/Guardian Signature _____

(Please see other side) →

STUDENT'S MEDICAL HISTORY (Check all that apply.)

Health Problem	Specify/Describe/Date	Medications	Special Needs
ADHD			
Allergies/Reactions			
Asthma			
Autism			
Behavioral/Mental Health Issues			
Bleeding Disorder			
Cancer			
Developmental Delays			
Eye/Vision Disorder			
Gastrointestinal Disorder			
Headaches			
Hearing Issues/Loss			
Heart Disorder			
Hospitalizations			
Neurological Impairment			
Orthopedic Impairment			
Respiratory Diseases			
Seizure Disorders			
Serious Accident/Injury			
Surgery			
Other			

➤ I give permission to release the above medical history to your child's teachers and staff.

Parent/Guardian Signature: _____

SPECIAL DIET & MEDICATION REQUEST

If your child has a severe food allergy and you would like to request a change/modified diet in school meals, please download the [Special Diet and Medication form](#) on the school website and return it in person to the nurse at your student's school. The form will need to be completed by your student's physician.

MEDICATIONS AT SCHOOL

The administration of ALL medications must be taken to the nurse's office in the original container and the parent/guardian must sign a medication consent form. When filling your child's prescription, please ask the pharmacist for two marked containers, one for home and one for school. Students may carry inhalers, EpiPens, and diabetes supplies on their person, but the parent/guardian still must check in with the nurse and sign a consent form. The school nurse, or designee, may administer over the counter medications (students may not carry their own on their person). Arizona State law recommends that written permission be given before administration of any medications.

*****Please mark a line through any of the following medications you DO NOT want your student to take.**

Topical Medicines	Medicines Taken By Mouth
Allergy Relief Eye Drops//Sterile Saline Solution Eye Wash	Acetaminophen (Tylenol)
Aloe Vera Gel	Ibuprofen (Advil, Motrin)
Bacitracin	Antacids - (Calcium-Based, ie. Tums)
Benadryl Cream	Benadryl (Diphenhydramine- allergic reaction only)
Calamine/Caladryl Lotion	Cetirizine (Seasonal allergies, ie. Zyrtec)
Hydrocortisone Cream	Cough/Cold Syrup-(Guaifenesin, Dextromethorphan HBR)
Burn Relief Spray/Gel (Lidocaine)	Cough Drops/Sore Throat Lozenges
Sting Kill Swabs (Benzocaine)	Anbesol/Orajel

➤ I give permission for my child to receive any of the above listed medications while attending PUSD.

Parent/Guardian Signature: _____ Date _____