Grade ____
Year ____

Clear Lake Christian School
Authorization and Consent to Provide Emergency Medical Care

My child, _________________________________ (full name of student), is now in my custody and under my authority. I authorize Clear Lake Christian School and/or its representatives to consent to emergency medical treatment of my child in case of any illness or injury in connection with a school activity or school trip. Such treatment may be administered by physicians, other medical personnel, hospitals, and/or clinics as may be selected by Clear Lake Christian School and/or its representative. I hereby assume responsibility for such professional service.

Hospital Preferred ______________________________

Physician ______________________________

Physician Phone (   ) ______________________________

Student is covered by an insurance policy yes ☐ no ☐

Insurance Company ______________________________

Membership/Policy # ______________________________

☐ **I do** ☐ **I do not** authorize any such treating physician or medical personnel to administer blood or blood products to my child.

MEDICAL HISTORY

Date of Birth ___________________ (Month/Day/Year) Date of last Tetanus __________________ (Month/Day/Year) Student wears contacts? Yes ☐ No ☐

Allergies to medication ____

Other Allergies ____

Daily medications ____

Pertinent information about illness, surgery, or chronic conditions ____

Check if your child has had any of the following:

__asthma
__ diabetes
__ frequent sore throat
__ kidney disorder
__ seizures
__ chicken pox
__frequent earaches
__ frequent stomachache
__ muscular dystrophy
__ surgery
__ cerebral palsy
__frequent headaches
__ hearing loss
__ rheumatic fever
__ tuberculosis
__ cystic fibrosis
__frequent nose bleeds
__ heart disease
__ scarlet fever
__ other ____

EMERGENCY INFORMATION

Home Address ______________________________

City/Zip ______________________________

Home Phone (   ) ______________________________

Father's Name ______________________________

Employer ______________________________

Business Phone (   ) ____________________ ext: _____

Business Address ______________________________

City/State/Zip ______________________________

Pager ______________________________

Cell Phone ______________________________

E-mail ______________________________

Mother's Name ______________________________

Employer ______________________________

Business Phone (   ) ____________________ ext: ___

Business Address ______________________________

City/State/Zip ______________________________

Pager ______________________________

Cell Phone ______________________________

E-mail ______________________________

Local Relative or close friend who can be contacted when the parent cannot be reached:

Name ____ Phone (   ) ____________________ ext: ____________

Parent/Guardian's Signature (Must be signed in front of notary)

____ Date ______________________________

Subscribed and sworn to before me by said affiant on this day, to certify which witness my hand and seal of office this _______ day of ___________________, 20 __

____
Notary Public in and for the State of Texas

My commission expires; ______________________________

MEDICATION RELEASE

The school supplies the items listed below which cannot be administered to students without parental consent. Please check only the items that you will allow to be administered. If your child is currently on a daily medication (i.e. Ritalin, Amoxcil, Penicillin, etc.), please consult with your doctor to make certain that none of the items listed below, when administered, will conflict in any way with the medication. This would also apply to any medication given throughout the school year. Medication will be given in compliance with the directions on the product.

____ Acetaminophen (i.e. Tylenol etc.)

____ Ibuprofen (i.e. Advil, Motrin, etc.)

____ Antacid (i.e. Tums, etc.)

____ Benadryl

____ Insect Repellant

I am giving my permission for the health station attendant to give my child the medications I have indicated. I understand that I must provide all other medications, prescription or non-prescription if my child is to be given them at school.

I understand that all medications I send to school during the school year must be in the original container and accompanied by a written request which will include the following:

1. Date to be given
2. Student's Name
3. Name of the Medication
4. Dosage, which must include a physician's written direction if different from the recommended dosage of the manufacturer
5. Time to be given or how often
6. Signature of parent or guardian

If these criteria are not met, I understand that the school reserves the right not to administer medication to my child.

I understand that it is my child's responsibility to report to the designated area in the health station to take his/her medication. I also understand that all medications are to be turned in to the health station and not to be carried in the student's possession or stored in his/her locker.

I hereby indemnify Clear Lake Christian School and hold it harmless on behalf of myself, my spouse, if any, and my child against any and all loss, damage (economic or otherwise), health care provider or emergency transportation expense, or other costs and expenses, including but not limited to reasonable compensation of employees, agents and counsel in defending itself against claims or liabilities, arising out of or related to the administration of medication as requested and authorized herein unless it is proved that Clear Lake Christian School staff members or volunteers acted willfully or in reckless disregard of my child's health.

____ ________________________

Parent/Guardian Signature Date

****Unless this form is dated, signed and properly completed, your child will not be given medication during the school year. ****