Diocese of Fort Wayne – South Bend

Emergency Information

Christ the King Catholic School

The Information below *must* be kept on file in the school office. Complete this form for each child and send it back to school tomorrow. Parents must complete this form prior to the start of the school year. PLEASE PRINT!

Parents are responsible for informing the office during the school year if changes in emergency information occur.

Name of Child ______________________________ Grade __________

Name of Parent(s) or Legal Guardian(s) ______________________________

Address ______________________________ Preferred Phone ______________

City, State, Zip ______________________________

Parent Place of Employment ______________________ Work Phone ______________

Who should we call if there is an emergency regarding this child, and in what order should we call them?

(This list should include parents & guardians)

	Name	Relationship to Child	Phone Number(s)	Please check
1				____ Cell phone ____ Home ____ Work
2				____ Cell phone ____ Home ____ Work
3				____ Cell phone ____ Home ____ Work
4				____ Cell phone ____ Home ____ Work
5				____ Cell phone ____ Home ____ Work

CONSENT TO EMERGENCY CARE

In the event of an emergency, I request that the school make reasonable attempts to contact me at the above numbers or another parent/adult at the above listed numbers. I understand that in an emergency, difficult circumstances may prevent the school from contacting me immediately or the school may be unable to reach me. I therefore consent to the school's taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted.

I understand that decisions concerning the type of emergency medical care/treatment administered are made by health care providers and not by the school and that demanding circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child which the school may disclose to a health provider. (Check and complete any of the following)

______ Dr. ______________________________ is my preferred physician.

______ Dr. ______________________________ is my preferred dentist.

______ Receipt of my consent prior to my child's receiving major surgery, unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained before surgery is performed.

The school may disclose the following checked information to a health care provider:

______ Insurance Company: ______________________ Policy/Group/Claim # ______________

______ The following information regarding allergies my child has, medication my child is taking, and other medical facts about my child: ______________________________

I understand that in the event of an emergency, the school will make reasonable efforts to notify a health care provider of the above-checked information; but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date: ______________ Signature of Parent/Guardian: ______________________________

Epi Pen Consent & Release

Student_______________________________________

School __________________ Grade ________________

To be completed by a physician/practitioner:

My patient,_____________________________,has been instructed in the proper use of his/her Epi Pen. The Epi Pen I have prescribed is _______________ ______________________. My patient is authorized to use the Epi Pen as follows:____. The prescription for the Epi Pen expires_________________________________. This student's well being is in jeopardy unless the Epi Pen is given to him/her. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner:____

Please Print or Stamp

Address:____

Phone #_________________________________

Signature:_____________________________Date:______________________

To Be Completed by Parent/Guardian:

I permit my child to be given the above listed Epi Pen as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the Epi-Pen. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: ______________________________ Date: ___________

Lot #:_________________________ Expiration Date:___________________

To Be Completed by the Student:

I understand the purpose, appropriate method, and frequency of use of this Epi Pen. I understand that I, not the school, is responsible for the storage, possession, and use of the Epi Pen. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature:_____________________________________ Date:__________

- **This form must be completed in addition to the routine medication authorization form & the allergic reaction form.**

Inhaler Self-Administration

Student ______________________________

School ______________________________

Grade ______________________________

To be completed by a physician/practitioner:

My patient ______________________________ has been instructed in the proper use of his/her inhaler. The inhaler I have prescribed is ______________________________. My patient is authorized to use the inhaler ________ times per day or as follows: ______________________________. The prescription for the inhaler expires ______________________________. This student's well being is in jeopardy unless the inhaler is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner: ______________________________
Please Print or Stamp

Address: ______________________________

Phone # ______________________________

Signature: ______________________________ Date: ______________________________

To Be Completed by Parent/Guardian:

I permit my child to carry the above listed inhaler as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: ______________________________ Date: ______________________________

To Be Completed by the Student:

I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: ______________________________ Date: ______________________________

- **This form must be completed in addition to the routine medication authorization form.**

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Nebulizer Consent & Release

Student______________________________________

School _________________ Grade ______________

To be completed by a physician/practitioner:

My patient, _______________________________,has been instructed in the proper use of his/her nebulizer. The nebulizer I have prescribed is _____________________________________. My patient is authorized to use the nebulizer as follows: ____. The prescription for the nebulizer expires_____________________________.

This student's well being is in jeopardy unless the nebulizer is given to him/her. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner:

____

Please Print or Stamp

Address: ____

Phone #_______________________________

Signature: ____________________________Date:____________________

To Be Completed by Parent/Guardian:

I permit my child to be given the above listed nebulizer as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the nebulizer. I understand that sharing ~~medication with other students~~ will result in disciplinary action.

Parent/Guardian Signature: ____________________________ Date: ___________

Lot #:________________________ Expiration Date:___________________

To Be Completed by the Student:

I understand the purpose, appropriate method, and frequency of use of this nebulizer. I understand that I, not the school, am responsible for the storage, possession, and use of the nebulizer. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature:____________________________________ Date:__________

- **This form must be completed in addition to the routine medication authorization form & the allergic reaction form.**

Written Consent for Administration of Medication

2014

Physician/Health Care Provider

In order to protect the health and welfare of the students and school staff alike, Indiana laws requires that parents consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medication to your student the form below must be read and signed.

1. The school **must have on record a written order from the prescribing physician/practitioner and written consent from the parent/guardian for prescription medication**. There must be a written request from the parent/guardian for Over the Counter (OTC) medications before they will be administered to a student at school.
2. Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following:
   - Student's Name
   - Name of Medication
   - Dosage of Medication
   - Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in at the office and kept in a locked cabinet.
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
5. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff can not take a physician order over the phone.
7. Over-the-counter medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

I have read and understand the above policy.

_____Please administer to ,____________________________, the prescribed medication(s) written below, in accordance with the written order of the physician/practitioner.

AND/OR

_____Please administer to ________________________, the over-the-counter medication(s) as described below:

Medication	Dosage (Mg and # of tabs)	Time	Precautions/side effects
1.			
2.			
3.			
4.			

- Period of time medication is to be continued:________________________________
- Reason for medication:____________________________________

Physician Signature:________________________________ Date_______________

Printed Name:________________________________ Phone #:_______________

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