EMERGENCY MEDICAL INFORMATION

Please complete and update the emergency medical information throughout the school year if information changes. It is important to have up to date contact information if your child becomes sick or injured. Medications, allergies, and other information such as **Asthma or other Chronic problems** need to be listed so emergency personnel are aware. Please be sure to sign the consent form to authorize any emergency treatment. This consent would also be sent with the squad to the hospital if your student needs emergency treatment.

ILLNESS DURING SCHOOL HOURS

A student who becomes ill during school hours must check in with the attendance office secretary to see the school nurse. The illness will be assessed and the Emergency Medical Authorization form will be utilized to contact parents or guardians as needed. Please make sure your Emergency Medical forms are kept up to date. (See Illness During School Hours in Student Handbook).

MEDICATIONS

Students are not permitted to carry medications on their person. There are exceptions for emergency Asthma Inhalers and Epi-pens if the proper Authorization for Prescription Medication or Treatment is completed by the parent and doctor.

Authorization for "Over the Counter" Non-prescription medication can be utilized for medications such as Tylenol or Ibuprofen. This requires only the authorization of the parent or legal guardian. All non-prescription medications will be locked in the clinic. Students are not authorized to carry these medications on their person.

All medications are to be in their original container. Please do not send medications in baggies, etc. A new form must be completed for your child's medication each new school year.

Please note that all these forms are available under the school nurse section on the schools website (http://www.nlsd.k12.oh.us/olc/teacher.aspx?s=80).

REQUIRED IMMUNIZATIONS PRIOR TO ENTRY INTO 7th Grade

Students in the **6th grade** are required to have the following vaccinations prior to entry into the 7th grade.

1. TDAP
2. Meningococcal immunization

Please turn into Middle School Office, or fax to (740) 743-3319 to the attention of Nurse.

EMERGENCY MEDICAL AUTHORIZATION

Northern Local School District

5341 F1
1/30/2013

_____ Sheridan HS _____ Sheridan MS _____ Glenford _____ Somerset _____ Thornville

Students Name (on line above) | Date of Birth | Grade | Box No. (for mailing purposes)

(Street Address) | (City) | (State) | (Zip)

Non-Residential Parent: _____

(Street Address) | (City) | (State) | (Zip)

PURPOSE: To enable parent and guardian to authorize the provision of emergency treatment for children who become ill or injured, when the guardian cannot be reached. **This is a state requirement**

CONTACT INFO: MUST BE COMPLETED AND UPDATED WITH CHANGES (and for Student Pick-Up)

Mother's Name Step__ Foster___ | Home Phone | Cell Phone | Workplace Phone

Mother's Email Address: _____

Father's Name Step__ Foster___ | Home Phone | Cell Phone | Workplace Phone

Father's Email Address: _____

Please complete at least 2 more contacts if parent cannot be reached:

Name Relationship _____ Phone | Name Relationship _____ Phone

Name Relationship _____ Phone | Name Relationship _____ Phone

PART I-CONSENT FOR TREATMENT

After being unsuccessful in reaching a number above, **I hereby give my consent** for:
(1)administration of any treatment deemed necessary by _____ (Preferred Physician) _____ (Phone)

or by _____ (Preferred Dentist) _____ (Phone) or by _____ (Counseling Center/Counselor) _____ (Phone)

or in event the designated preferred practitioner is not available, by another licensed physician or dentist and _____ (Preferred Hospital) or any hospital reasonably accessible. This authorization does not cover surgery unless the medical opinion of two(2) other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. This authorization also allows for transport per EMS services.

Note: ***This info needed for emergency personnel, please provide each school year.***

List Medication	***List Allergies***	***Physical Impairments***	***Other***
1.	1.	1.	1.
2.	2.	2.	2.

X

Parent or Guardian Signature (on line above) | **Date (on line above)**

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 illness or injury requiring treatment, I wish the school authorities to take no action or to:
1. _____

Parent or Guardian Signature | Date

Northern Local School District 5330 F1a

AUTHORIZATION for "Over-The-Counter" (Non-prescription) Medication or Treatment

_____ SHS _____ SMS _____ Glenford _____ Thornville _____ Somerset

1. Complete the following information.
2. Bring in medication in it's original container. (DO NOT place in baggie, etc.)
3. Do not exceed dosage as recommended by manufacturer.
4. Remember. Your child may NOT carry medications on their person.

_____ _____ _____
Name of Student Birthdate Grade

A. I am requesting permission for my child named above to use or receive the following over-the-counter medication (s). The student will self administer such medication in my presence or that of an authorized staff member.

☐ Ibuprofen (Motrin, Advil)
200mg
____1 tablet ____2 tablets
Every 4 to 6 hours if needed

Tylenol (Acetaminophen)
500mg
___1 tablet ____2 tablets
Every 4 to 6 hours if needed

☐ Other _____
Dosage _____ mg
_____ (tablets, caplets, capsules
Every _____ hours _____

☐ I have sent the above medication in the original bottle to be kept in the clinic for future use.

B. I will assume responibility for safe delivery of the medication to school.
C. I will notify the school immediately if there is any change in the use of the medication (s).
D. I release and agree to hold the Board of Education, it's officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____
Home Telephone Work Telephone

***NOTE: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up.

Revised 04/17/2018

TO BE COMPLETED BY SCHOOL PERSONNEL

Student	Sheridan Middle School School	Date Started	2019-20 School Year	Grade

Medication (Please Check)	Dose (Please Check)	Special Instructions:	Time to Dispense (Please Check)
☐ Ibuprofen 200mg ☐ Tylenol 500mg ☐ Other_____	☐ Tablet/Capsule/Caplet ☐ Other: _____		☐ Other: ☐ Every 4 to 6 hours as needed.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*						X	X					X	X
Sept	X	X					X	X						X	X						X	X					X	X		X
Oct					X	X						X	X						X	X					X	X				
Nov		X	X		X				X	X	X					X	X						X	X				X	X	X	X
Dec	X	X					X	X						X	X						X	X	X	X	X	X	X	X	X	X	X
Jan	X	X	X	X	X						X	X						X	X	X					X	X					
Feb	X	X						X	X					X	X	X	X					X	X						X	X	X
Mar	X						X	X						X	X	X					X	X					X	X		
Apr				X	X				X	X	X	X	X					X	X						X	X					X
May		X	X						X	X						X	X						X	X	X					X	X

Initials/Signature _____ Initials/Signature _____ Initials/Signature _____

KEY
Initials = Med taken within 1 hour of designated time
O = No medication available
X = No School
A = Absent
E =error

Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____
Date Bottle Home _____ Date Rec'd _____ Amt Rec'd ____ Initials _____

Date Medication Brought In: _____

AUTHORIZATION FOR PRESCRIPTION MEDICATION OR TREATMENT

Name of Student: _____ DOB: _____

Street _____ PO Box _____

City _____ State _____ Zip _____

School: _____

Part A: To be completed by the physician

I have prescribed the following:

Medication/Treatment _____

Dosage _____

Time to be given at school _____

If **Asthma inhaler** may student carry on person: _____

If **Epi-pen** may student carry on person: _____

Is student trained to self administer medication? _____ Yes _____ No

Begin Date: _____ End Date: _____

Side effects, Instructions, or precautions:

_____

_____

_____

_____ _____

Physician's Signature Date

_____

Telephone

_____ _____

Doctor Printed/Typed Name Fax

Part B: To be completed by the Parent /Guardian

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school: to notify the school if there is a change in physicians: to notify the school if the medication, dosage, or procedure is changed or discontinued. I give my consent to the physician, school nurse, or their designees to send and/or receive information related to my child's health as they deem appropriate for the duration of this order as noted above.

***Please note medication must be in pharmacy labeled bottle.**

DATE _____ Signature of Parent/Guardian _____

****Note: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up

Revised 5/13/2015