CLHS EMERGENCY INFORMATION FORM

Student Name _____ _____ _____ _____ _____
(Last) (First) (Middle) (Sex) (Grade)

Custodial Parent / Guardian Name _____ _____ _____
(Relationship) (Work Phone Numbers)

Address _____ _____ _____
(Street) (Student Date of Birth) (Home Telephone)

_____ _____ _____
(City) (State) (Zip Code) (Parent/Guardian Cell Phone) (Parent/Guardian Cell Phone)

Physician _____ Dentist _____
(Telephone) *(Telephone)*

Emergency Contact - other than parent _____
(Name) (Relationship) (Telephone)

Hospital Preference _____

Special Student Health Information (Diabetes, Heart, Allergies, Medications, Recent Surgeries/Injuries, etc.)

☐ **Inhaler** *Copy of prescription must be on file with nurse*

_____

_____

_____

Over-the-counter / Prescription Medication Authorization

I give permission for my student to receive the following medications during school hours by the nurse or designated personnel at CLHS. *(Check appropriate spaces)*

☐ Over-the-counter medication @ $0.25 per dose to include the following: Tums, Ibuprofen, Pepto-Bismol and non-ASA pain reliever available in CLHS clinic.

☐ I will provide the following over-the-counter medications to be kept for my student's personal use, which will include original manufacturer's label with dosage instructions and length of time to be dispensed.

_____

☐ I will provide the following prescription medications in the original pharmacy container, prescription label intact and current dosage indicated. Any change in dosage will require new container with new dosage prescription label.

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To ensure the safety of your child, pertinent health information may be provided to appropriate school staff/personnel.

In case of an emergency involving your child, it is the policy of CLHS to render first-aid treatment while contacting the parents/legal guardians for further instructions. Only after reasonable efforts to reach the parents/legal guardians without success, in circumstances that warrant immediate treatment, 911 will be contacted.

You have my permission to act accordingly. You also have my permission for this student's physician to be contacted with questions regarding medications, if required.

_____ _____
Parent/Legal Guardian Signature Date