SANBORN REGIONAL SCHOOL DISTRICT
EMERGENCY FORM

This form will accompany your child to the hospital in a medical emergency. Please read and complete all areas of this form. Note that 2 signatures are required.

Student's Last Name: Student's First Name: Gender: Grade:

Street Address: Town: Telephone:

Mailing Address: Place of Birth: D.O.B:

Mother's Full Name: Mother's Cell: Mother's Work Phone:

Father's Full Name: Father's Cell: Father's Work Phone:

Father's Email: Mother's Email:

With whom does this child reside? Mother, Father, Parents, or Other (Specify):

Are there any special child custody provisions? Yes or No: If yes, please send any appropriate legal documentation.

Has either the student or a parent moved or changed a phone number in the past year? YES OR NO

List two neighbors or relatives who will assume temporary care of your child if you cannot be reached:

1. Name: Address:
   Relationship: Home Phone: Cell Phone:
2. Name: Address:
   Relationship: Home Phone: Cell Phone:

Child's Routine Daily Medications: (Name and Dosage Amounts)

Known Allergies (Food, Drug, Environmental):

Health Conditions:

Local Physician's Name: City/Town: Phone:

Dentist Name: City/Town: Phone:

Hospital of Choice for Emergency Transport:

The information on this card may be shared with school staff and emergency personnel as appropriate. It is the parent's / guardian's responsibility to share your child's medical condition and treatment with transportation personnel (bus drivers).

Signature of Parent / Guardian: _____ Date:_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and follow his or her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

Signature of Parent / Guardian: _____ Date:_____

SANBORN REGIONAL SCHOOL DISTRICT

MEDICATION ADMINISTRATION PERMISSION CARD

Student's Last Name: _____ Student's First Name: _____ Gender: _____

Known Allergies (Food, Drug, Environmental):

_____

The health office supervises the administration of yearly vision and hearing screenings within the school. Parents/ guardians will be notified of any abnormal results. Please place an "X" in front of the screenings that your child may participate in.

- ☐ **Hearing and Vision screenings**
- ☐ **Hearing screening only**
- ☐ **Vision screening only**

The health office will stock the following medications and will administer those checked off by a parent or guardian. These will be administered according to the package directions at the discretion of the school nurse. **THIS FORM WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR.** Please place an "X" in front of those medications the school nurse may administer to your child:

- ☐ All medications listed below
- ☐ Tylenol or generic acetaminophen for pain, headache, or fever
- ☐ Bacitracin ointment or generic to wounds
- ☐ Caladryl lotion or generic for minor rash or insect bites
- ☐ Hydrocortisone cream ½% for minor rash or insect bites
- ☐ Topical oral anesthetic (Orasol, Ambesol, or generic) for minor dental pain
- ☐ Mylanta, Tums, or generic for minor stomach upset
- ☐ Throat lozenges / cough drops, for minor sore throat or cough

NOTE: If a parent / guardian requests administration of non-prescription medication not noted in the above list, the medication should be brought to the Health Office in the original container by a parent / guardian and a Hold Harmless form should be completed.

I, the parent/guardian, authorize the school administrator to direct members of the school staff to assist my child in taking the above medication and agree that I will not hold liable, any member of the school staff or an individual of official capacity who is directed by me (parent / guardian) and the school administrator to assist my child in taking said medication.

Signature of Parent / Guardian: _____ Date:_____