Authorization of Emergency Medical Care

Student Name______________________ **Birthdate**____________________ **Grade** ___________

Home Phone__________________ **Address**____

<u>Purpose</u> – *To enable parents and guardians to authorize the provision of emergency treatment for children who became ill or injured while under school authority, when parents or guardians cannot be reached.*

Emergency Contact Information:

Mother's Name _______________________________ **Daytime Phone** _________________________

Father's Name ________________________________ **Daytime Phone** _________________________

Other's Name/Relation _________________________ **Daytime Phone** _________________________

Part I or II must be completed

<u>Part I – To Grant Consent</u>

I hereby give consent for the following medical care provider to be called:

Physician Name ____

Physician Address ____

Physician Phone Number ____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by (1) another licensed physician; (2) emergency medical personnel or (3) the transfer of the child to any hospital reasonably accessible.

Facts concerning the child's medical history including allergies, medications being taken, medical conditions and any physical impairments to which the physician should be alerted:

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__________________________________ __________________________________

Signature of Parent/Guardian **Date**

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<u>Part II – Refusal of Consent</u>

(Do not complete this portion if Part I was completed)

In the event reasonable attempts to contact me have been unsuccessful, I do <u>NOT</u> give my consent for emergency medical treatment of my child. In event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

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_______________________________ _______________________________

Signature of Parent/Guardian **Date**

ADMINISTRATION OF MEDICATION AUTHORIZATION

Student Name_______________________ **Grade** ______________ **School Year** _________

Emergency Contact(s): [Name (Relation) and Phone Number]

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Brookhaven Innovation Academy encourages that medication be taken at home before school hours or after school when possible. However, when necessary, students may be assisted by school personnel with the administration of medication. Permission for assisted administration of prescription or over the counter medication must be granted to Brookhaven Innovation Academy personnel through completion and return of this form.

- **Prescription medication will only be administered if prescribed by a physician and the school has received the completed physician authorization attached to this form.**
- **Over-the-counter medication will only be administered if provided to the School by the parent or guardian with clear instructions.**
- **Physician authorization is needed if over the counter medication will need to be administered for longer than one week,**
- **Prescription medication must be delivered to the school by a responsible adult in the container in which it was dispensed as ordered by prescribing physician. Pharmacist can provide a duplicate labeled container with only the school doses. Over-the-counter medications must be in their original container.**
- **A separate permission form is required for each medication to be given. A new form and authorization must be completed each school year, or with any changes to medication, dosage or administration time.**
- **Parents are responsible for noting the expiration date of all medication. Expired medication will not be given at school.**
- **Any medication not picked up by the last day of school will be destroyed.**
- **With limited exception, all medication must be kept in the designated location.**
- **The first dose of all new medications or new medication dosages will not be given for the first time while in School**

I hereby grant to the principal or designated staff member to administer or assist my child with the self-administration of the medication listed below in accordance with Brookhaven Innovation Academy's policies. I understand that it is my responsibility to inform the school of any medication changes. New medications or new doses **will not** be given unless a new prescription or over the counter medication authorization is completed.

I authorize the prescribing named physician to discuss with the principal or designated staff member any matter regarding the medication to be administered.

I acknowledge that the administration of medication is a courtesy and I (we) agree to indemnify Brookhaven Innovation Academy, and any individual officer, employee, agent or representative ("Brookhaven Innovation Academy Representatives"), against, and hold, save, and defend Brookhaven Innovation Academy Representatives harmless from, any and all claims, demands, actions, causes of action, suits, liabilities, damages, losses, costs and expenses of any kind or nature whatsoever (including, without limitation, attorneys' fees and expenses and any other costs) which Brookhaven Innovation Academy Representatives may suffer or incur, or which may be asserted against Brookhaven Innovation Academy Representatives arising out of these actions. I further acknowledge that Brookhaven Innovation Academy

Representatives shall be held harmless for the provision of emergency medical service if I (we) have not provided adequate medication for my (our) student.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), disclosure of certain medical information is limited, I hereby authorize disclosure of pertinent medical information for the provision of services for my child while in attendance at Brookhaven Innovation Academy. This authorization expires on the last day of this school year, including summer/extended year session.

Parent/Guardian Signature___________________________ **Date** ___________

PARENTAL AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

Student Name ____

Name of Medication ____

Quantity Provided _______________________ **Expiration Date** _____________________

Dosage ______________________________ **Frequency** ________________________________

Conditions for which OTC medication may be administered __________________________
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By not including conditions for administering OTC medication, I (we) authorize Brookhaven Innovation Academy and its personnel to use reasonable judgment when providing this medication to my (our) student.

Parent/Guardian Signature ________________________________ **Date**________________

Physician Authorization for All Prescription Medications and over the counter medication that will be needed for more than one week

(Completed by Physician)

Name of Student/Patient ____

Name of Medication ____

Dosage____

Frequency/Time to be given ____

Form of Medication: • Tablet/Capsule • Liquid • Injection • Nebulizer • Other ____________________

Termination Date for Administering Medication ______________________________

Reason for Medication ____

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Restrictions/Special Instructions/Important Side Effects

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<u>Asthma Medication or Auto-Injectable Epinephrine</u>

(please do not fill out this section without first discussing with Brookhaven Innovation Academy Registered Nurse)

May child carry medication during the school day due to a life-threatening condition? • Yes • No

Is child able to self-administer this medication? • Yes • No

Name of Physician ____

Phone______________________________ **Fax** ______________________________

Address ____

Physician's Signature ______________________________ **Date** ____________________

Retention & Self-Administration of asthma medication or Auto-Injectable Epinephrine

*** This form must be completed and returned with an accompanying signed physician authorization annually or more frequently if the medication, dosage, frequency of administration, or reason for administration changes.***

Pursuant to OCGA §20-2-774 and OCGA §20-2-776, students may be able to retain and carry prescription asthma medication or auto-injectable epinephrine on their person for self-administration as prescribed by a licensed physician for regular or emergency use.

Student Name ____

Name of Medication ____

I (we) consent to the retention and self-administration of the above-named medication by my (our) student while in school, at a school sponsored activity, while under the supervision of school personnel, or while in before- or after-school care on school property. I (we) authorize designated school personnel to consult with my (our) student's authorizing physician regarding any questions that may arise with regard to the medication. I (we) release all Brookhaven Innovation Academy employees, agents, officers, and representatives from liability for any adverse reaction suffered by my (our) student as a result of self- administration. I (we) understand that my (our) student may be subject to disciplinary action if he/she abuses or misuses the identified medication or if he/she uses it in a manner other than as prescribed.

Parent/Guardian Signature ______________________________ **Date** __________________

School Use Only
Physician Authorization Provided? • Yes • No