Full Circle School

Health Form/Emergency Medical Consent

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians and attempts to contact them may not be feasible or have been unsuccessful. This form, or an electronic copy of this form, should be accessible in the event of off-site trips or emergency relocation of the program.

Child's Name: _____ Birth Date: _____

Address: _____

Parent/Guardian/Primary Contact: _____

Cell/Primary Phone: _____ Business/work phone: _____

Business Name/Address: _____

Please list in order of desired contact, up to 3 adults who can assume responsibility for your child in the event the primary contact cannot be contacted.

Adult 1: _____ Relationship: _____ Day Phone: _____

Adult 2: _____ Relationship:_____Day Phone: _____

Adult 3: _____Relationship: _____Day Phone: _____

Physician name: _____ Phone: _____

Insurance information, if applicable:

Company: _____ Group/ID #: _____

Name on Insurance Card: _____

MEDIC ALERT: Please provide information critical to staff or to a first responder during an emergency (i.e. diabetic, severe allergies, etc.) Also list any specific prescription medications that are used to treat these conditions.

_____

_____

Allergies (food, meds, plants) not listed above: _____

_____

Special disability (if any): _____

_____

Additional health concerns (dietary, medical, psychological) not listed above:

_____

_____

Does this student take medications (daily or as needed) for any condition? _____

Please list:_____

Will the student take daily, or as needed, prescription medications at school? _____

If yes, please list: _____

Medical authorization forms are needed for prescription medications that must be administered/overseen by staff on a daily or as needed basis. Additional information on procedures for providing these medications is found in the Authorization and Consent to Medical Treatment section.

AUTHORIZATION AND CONSENT TO MEDICAL TREATMENT

Understanding that may child may need emergency or non-emergency treatment when he/she attends school, I hereby authorize Full Circle School staff or other qualified personnel to administer such first aid or other medical treatment as deemed best under the circumstances, and I consent for my child to receive such treatment when he/she attends Full Circle School, school sponsored events, or school sponsored field trips.

I understand that school staff will attempt to notify me in the event of an emergency requiring immediate medical care for my child. If the school is unable to notify me or an emergency contact, they will transport or accompany ambulance transport of my child to the nearest hospital or emergency center where he/she will receive treatment by a duly qualified physician. Any medical information provided to the school may be shared with emergency medical personnel. This authorization applies to all school-sponsored programs.

I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes, in writing, as they occur, i.e. telephone numbers, work changes, emergency contact changes, physician and health status changes. I agree to notify the school if my child has or is exposed to any communicable disease.

I understand that only medication which has been pre-approved will be dispensed to my child without prior approval from myself or an approved emergency contact. Short term OTC, homeopathic, or prescription medications I provide for my child to use must be in original containers and include written authorization, which includes the child's name and specific information required to administer the medication. I understand that long term daily or as-needed medications, whether OTC or prescription, that must be kept at school will require the above listed requirements to be met and a school medical authorization form signed by the parent/guardian and the child's physician.

_____ _____

Parent/guardian name—PRINTED Parent/guardian signature

_____ _____

Child's name—PRINTED Date

Full Circle Schools

1571 Lockett Rd
Rice VA 23966

Authorization Form
Non-prescription Over-the-Counter Skin Products

INSTRUCTIONS:
This form must be completed by the parent/guardian to authorize the use

- of Sunscreen
- Diaper ointment or
- cream Insect repellent
- Antibiotic Ointment

_____ has my permission to apply the non-prescription
(Name of Provider)

over-the-counter (OTC) skin product listed below to my child, _____.
(Child's name)

Product Name:

_____
_____
_____

Known Adverse Reactions (if any):

_____
_____
_____
_____

- All OTC products must:
  - Be in the original container and, if provided by the parent, labeled with the child's name
  - Be used according to manufacturer's recommendation and instructions for application
  - Not be used beyond the expiration date of the product

- Sunscreen:
  - Must have a minimum sunburn protection factor (SPF) of 15
  - Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
  - Children nine yrs. and older may self administer sunscreen if supervised

- Diaper ointment/cream and Insect repellents:
  - Shall be kept inaccessible to children
  - Record of use shall be kept that includes child's name, date, frequency of application, and any adverse reactions

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Parent's Signature: _____ Date: _____