STREAM and DRAMA CAMP Emergency Medical Authorization

Student _____ Grade in 2019 – 20 _____

Address _____ Phone_____

Mother's Name _____ Phone _____

Email _____ Email _____

Father's Name _____ Phone _____

Email _____ Email _____

Alternate Contacts: (In a medical emergency, we will contact these individuals if neither parent can be reached)

Name _____ Relation_____Phone_____

Email _____Phone_____

Name _____ Relation_____Phone_____

Email _____Phone_____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medication conditions which the school or emergency physician should know. _____

_____

_____

Medications are to be placed inside a plastic zip lock bag labeled with your child's name and should be brought to the camp by parents. Children are NEVER to transport medications. All medications, including prescription and OTC meds MUST be accompanied by a physician's signed orders and include dose instructions. NO EXCEPTIONS. OTC medications include aspirin, Tylenol, cough drops, etc. If your child requires an inhaler, please request a form.

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____ Daytime Phone_____

Dentist_____ Daytime Phone_____

Medical Specialist_____ Daytime Phone_____

Local Hospital _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted: _____

_____

Signature _____ Date_____

Refusal to Consent

I do NOT GIVE my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

_____

Signature_____ Date_____