EMERGENCY MEDICAL AUTHORIZATION
GROVE CITY HIGH SCHOOL BAND

School Year 2024 / 2025
Ohio Revised Code 3313.712

Student Name _____ Address _____

Date of Birth _____ _____

Grade _____ Telephone _____

Purpose - To enable parents and 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.

Residential Parent(s) or Guardian

Mother's Name_____ Phone:Home_____ Work_____ Cell_____

Father's Name _____ Phone:Home_____ Work_____ Cell_____

Other's Name (Guardian)_____ Phone:Home_____ Work_____ Cell_____

Name of Relative or Childcare Provider_____

Relationship _____ Address _____

Phone _____ _____

EITHER PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor _____ Office Phone _____

Dentist _____ Office Phone _____

Medical Specialist _____ Office Phone _____

Hospital _____ E.R. Phone _____

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.

See reverse side for facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted.

Signature of Parent/Guardian _____

Date _____

PART II - 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 of Parent/Guardian _____

Date _____

MEDICAL INFORMATION

Allergies (including medications, foods, or environmental) _____

_____

_____

_____

Medications taken at least once a month (including over-the-counter and prescription)

Name of Drug	Dosage	How Often	Reason for Drug
1.			
2.			
3.			
4.			

(Attach an additional sheet of more medications are taken)

Facts concerning the child's medical history and any physical impairment to which a physician should be alerted:

_____

_____

_____

The following over-the-counter medications may be available to your student if needed, is he/she chooses to take them. Please check whether or not your student may take each drug.

MEDICATION	COMMON REASON FOR GIVING	ALLOWED TO TAKE	MAY NOT TAKE
Acetaminophen (Tylenol)	Mild pain, headache	☐	☐
Ibuprofen (Motrin, Advil, or Aleve)	Mild pain, inflammation, muscle pain, swelling	☐	☐
Benadryl & Antihistamines	Itching and swelling with insect bites, congestion with colds	☐	☐
Sudafed	Congestion	☐	☐
Immodium	Diarrhea	☐	☐
Mylanta, Maalox, Tums, & Pepcid AC	Upset stomach, hearthburn	☐	☐
Cough syrup & Guaifensin	Coughing	☐	☐
Dramamine	Motion illness	☐	☐

Nothing on this form shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with the provisions of this form or section 3313.712 of the Ohio Revised Code.

Please use the space below (or attach an extra sheet) if there is anything else we should know regarding your child's medical history or medications:

RN-M003
Revised: 04/23

South-Western City School District

School Medication Permission and Instruction Form

School: Grove City High School Phone: 614-801-3300

Address: 4665 Hoover Road, Grove City, OH 43123 Fax: 614-871-6563

This form must be completed with physician and parent/guardian signatures. The required written information must be received, before any medication can be administered at school AND/OR, if the student is carrying an inhaler/epipen.

Parent Permission Date: _____

Student's Name: _____ Birth date: _____

Address: _____ Home Phone: _____

Daytime Phone: _____

School: Grove City High School Grade: _____ Teacher: Jason Graham

I hereby request and give permission to the PRINCIPAL or his/her DELEGATE (school nurse or other responsible person) to administer the medication routine described below and to communicate as needed with the prescribing physician. I understand that I am responsible for delivering the prescribed medication to the student's school in its original container (as labeled from the pharmacy) and for assuring that an adequate supply of the medication has been provided to the school.

If the Health Care Provider has indicated that the student should be permitted to carry an inhaler and/or epipen at school, I understand that the student is responsible for its proper maintenance and use. I understand that if the student is found to have shared his/her medication with other students or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler and/or epipen at school, and disciplinary action may occur. I understand, and have informed the student, that (s)he must notify the school bus driver, principal, nurse or teacher if his/her inhaler/epipen is lost or is taken from him/her by another person.

Parent Signature: _____

Physician's Direction

The above named student is under my care and should receive the following.

Medication: _____ Dosage: _____ Route: _____

at these times: _____

Other specific instructions for administration:

Inhaler/Epipen Only:

The student knows and understands the proper use of his/her inhaler/epipen ◯ Yes ◯ No

The student should be allowed to carry it on his/her person. ◯ Yes ◯ No

Possible side effects to watch for:

Expiration date of this request: _____

Doctor requests teacher's comments

◯ Yes: Please observe the following:

◯ No: Teacher comments unnecessary

Physician Name (Please print or type): _____

Physician Signature: _____

Physician Phone Number: _____

Physician Fax Number: _____

Date: _____

STAFF: A copy of this form must be provided to the school nurse if the form is given to any other SWCSD staff member.

RN-M004
Revised: 04/23

South-Western City School District

Authorization for Non-Prescription Over-the-Counter Medication or Treatment

3805 Marlane Drive ● Grove City, Ohio 43123 ● (614) 801-3000 ● www.swcsd.us

To the Parent/Guardian:

The following information is necessary for any student to use non-prescribed, over-the-counter medications while in school. All spaces must be completed.

Name of Student: _____

Address: _____

School: Grove City High School Grade: _____

A. I am authorizing permission for my child (named above) to: (Check one or both)

☐ Use or receive the following over-the-counter medication(s):

Medication: _____

Medication: _____

Note: medication dosage will be determined using the recommended dosage identified by the provider of the over-the-counter medication. Any dosage request larger than the provider's recommendations must be approved by a physician

☐ Self-administer such medication(s) in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school.

C. Provider-recommended dosage instructions must accompany any medication

D. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

F. I understand that if my child performs any care tasks for the purpose other than the student's own care, or evidence is found that the student is abusing the use of the non-prescribed medication(s), the Board will revoke the student's permission to use or receive over-the-counter medications at school.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Home Phone Number Work Phone Number

STAFF: A copy of this form must be provided to the school nurse if the form is given to any other SWCSD staff member.

_____

Signature of Principal / Designee