

Grade _____

Homeroom Teacher (Pre K-5th) _____

Broken Arrow Public Schools Emergency Information and Authorization to Administer Non-prescription Medications

Student's Name: _____ Birth date _____ Sex: M / F
Last First Middle

Address: _____
Street City Zip

Parent/Guardian (First contact) _____ Relationship: _____

Phones:(H) _____ (W) _____ (Cell) _____

Parent/Guardian (Second contact) _____ Relationship: _____

Phones:(H) _____ (W) _____ (Cell) _____

Other Contacts

Please list anyone authorized to pick up your student, in the event of illness or injury, if you cannot be reached at the above numbers. **Only those persons listed will be allowed to pick up your child without additional approval from you.**

Name: _____ Relationship: _____ Phone:(H) _____ (W) _____ (Cell) _____

Name: _____ Relationship: _____ Phone:(H) _____ (W) _____ (Cell) _____

Health History

Physician: _____ Phone _____ Insurance: _____

Does your student have any **potentially life threatening allergies** to medicine or anything else? **yes/no** (If yes, explain) _____

Does your student have any chronic or significant **health problems, or any physical limitations**? **yes/no** (if yes, explain) _____

Is your student being treated with **any prescription medications at home or school**? **yes/no** (If yes, list) _____

Authorization to Administer Non-Prescription Medication

I hereby authorize the school nurse, or other school personnel designated to administer medications, to administer **acetaminophen** (Tylenol), **ibuprofen** (Advil/Motrin), **calcium antacid** (Tums), or **other non-prescription first aid medications** to my student **with the following exclusions:**

Students in grades 6-12: Students will receive authorized medications at the discretion of school personnel **except as excluded** by parent/guardian above.

Students in grades Pre-K-5: No acetaminophen, ibuprofen, or antacid medication will be given to students until verbally authorized by a parent/guardian.

Note: Only a parent or legal guardian may authorize the administration of medications.

Authorization for Treatment

I hereby authorize any physician, surgeon, or dentist on the medical staff of the nearest medical facility, to administer any emergency treatment, procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. **If this is not satisfactory**, please list specific emergency instructions in the event that you cannot be reached.

Signature of parent/guardian: _____ Date _____