

Emergency Contact & Medical Authorization Form

School Year: 2018-2019

PLEASE FILL OUT BOTH SIDES OF THIS FORM.

Student (please print): _____ Grade: _____

Parent/Guardian name: _____ Phone number: _____

If my child becomes ill and a parent/guardian cannot be reached, please call the following people:

Name	Relationship to Student	Telephone	Pick Up
1.			<input type="checkbox"/>
2.			<input type="checkbox"/>
3.			<input type="checkbox"/>

Please check the "Pick Up" box if this person is permitted to pick up your student. Anyone not included here will require parental approval in order to sign a student out of school and will be denied if we cannot reach a parent/guardian to verify.

Please list any condition(s) your child has that might result in a medical emergency, along with any necessary instructions for the staff:

Will your child need to take any medication (prescription and/or over-the-counter) at school?

Yes No

If yes, a **Medication Authorization Form** (on reverse side) **MUST** be completed and signed by a parent/guardian. **Prescription medication requires the signature of a medical professional.** CVA does have cough drops and Ibuprofen available for students, but consent **must** be provided before any medication can be administered at school.

Medical Emergency Authorization:

In the case of a serious accident or illness when I cannot be reached, I hereby authorize the doctor or treatment center below to treat my child. If it is necessary, an ambulance can be called and the cost of the ambulance is my responsibility.

Hospital Preference: _____ Telephone: _____

Dr. Name/Clinic: _____ Telephone: _____

I certify that all information provided on this form is true and accurate and that I have not withheld information from Cyber Village Academy concerning the enrolled/registering student.

Parent/Guardian Signature

Date

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This form must be filled out if student will be taking any prescription and/or over-the-counter medication while at school. If no prior consent is given here, we will call home when a student asks for Ibuprofen for headaches, etc.

Student (please print): _____ Grade: _____

Diagnosis/ Reason Given	Medication	Dosage	Time/Frequency	Possible Side Effects

Administration Procedure: _____

Other Comments/Information: _____

Note: Parent/Guardian is responsible for giving any necessary medication (prescription and over-the-counter) to office staff directly. **CVA will not accept medication brought in by student.** Medications will be kept in a secure location and administered by staff as appropriate/necessary.

Parent/Guardian Release:

1. I request medication be given as directed above.
2. I release school personnel from liability in the event that any reaction results from the medication.
3. If there is any remaining medication, I give my permission for school personnel to send this home with my child.

Parent/Guardian Signature

Date

Prescribing Physician's Name (prescription medications only): _____

Physician Signature: _____ **Date:** _____