CyberVillage
ACADEMY
Inspiring, challenging, and preparing students on campus & online

Emergency Contact & Medical Authorization Form

School Year: 2016-2017

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 (please print) **Relationship to Student** **Telephone**

1. _____
2. _____
3. _____

Please list any condition(s) your child has that might result in a medical emergency, along with any necessary instructions for the staff (please continue on a separate sheet if you need more room):

_____

_____

Will your child need to take any medication (prescription and/or over-the-counter) at school? (Please circle one and complete information on reverse side): Yes or No

If yes, a **Medication Authorization Form** (on reverse side) **MUST** be completed and signed by the parent/guardian. **Prescription medication requires the signature of a medical professional**. This consent **must** be provided before any medication can be given at school. The school does have Tylenol and Ibuprofen available for students, but we must have authorization in order to give it to any student for headaches, etc.

Medical Emergency Authorization:
In the case of a serious accident or illness and 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 child.

_____ _____
Parent/Guardian Signature Date

768 Hamline Ave. S
St. Paul, MN 55116
www.cybervillageacademy.org
Phone: 651-523-7170
Fax: 651-523-7113

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PLEASE NOTIFY OUR OFFICE OF ALL ADDRESS AND/OR TELEPHONE NUMBER CHANGES.

This form must be filled out if student will be taking any prescription and/or over-the-counter medication while at school.

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 getting any necessary medication (prescription and over-the-counter) to the school. Unless otherwise specified, medications will be kept in a secure location and administered by the 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**:_____