Authorization to Treat a Minor & Emergency Contact Information

In case of a medical emergency I (we), the undersigned parents or legal guardians of ___________________________________ a minor, do hereby authorize the doctors on duty as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, or any surgical diagnosis or treatment and any hospital care which is deemed advisable by, and is rendered under the general supervision of any physician or surgeon licensed under the provisions of the medical practice act, whether such diagnosis is rendered at the office of said physician or at a hospital. In case of such a medical emergency, it is understood that Illinois Lutheran Schools will use the best efforts possible to contact the undersigned to obtain advance parental consent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforesaid physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provision of the Civil Code of Illinois.

________________	____	___________________
Child's Birth Date	Signature of Parent/Guardian	Date

IN CASE OF A MEDICAL EMERGENCY, PLEASE CONTACT:

Name: ____ Relationship: _______________________________________
Phone Number(s): ____
Name: ____ Relationship: _______________________________________
Phone Number(s): ____

ALLERGIES & SENSITIVITIES

Penicillin or other antibiotics	❑ Yes	❑ No	______________________________
Morphine, Codeine, Demerol or other narcotics	❑ Yes	❑ No	______________________________
Novocaine or other anesthetics	❑ Yes	❑ No	______________________________
Aspirin, emperin or other pain remedies	❑ Yes	❑ No	______________________________
Sulfa drugs	❑ Yes	❑ No	______________________________
Tetanus antitoxin or other serums	❑ Yes	❑ No	______________________________
Adhesive tape	❑ Yes	❑ No	______________________________
Iodine or merthiolate	❑ Yes	❑ No	______________________________
Any other drug or medication	❑ Yes	❑ No	______________________________
Any foods, such as eggs, milk, chocolate	❑ Yes	❑ No	______________________________
Bee stings or other insect stings/bites	❑ Yes	❑ No	______________________________

DRUGS RECENTLY TAKEN

Cortisone	❑ Yes	❑ No	______________________________
ACTH	❑ Yes	❑ No	______________________________
Anticoagulants	❑ Yes	❑ No	______________________________
Tranquilizers	❑ Yes	❑ No	______________________________
Hypotensives	❑ Yes	❑ No	______________________________
Other	❑ Yes	❑ No	______________________________

OTHER MEDICAL INFORMATION

Has the child ever received treatment for Asthma, Rheumatism, or Rheumatic Fever? ❑ Yes ❑ No
Other medical information: ____
Doctor's Name: ____ Doctor's Phone: ______________________________
Insurance Company: ____________________________________ Policy/Group #: ______________________________

PERMISSION TO ADMINISTER MEDICATION

When no other plan is feasible, school personnel will cooperate in giving of medication at the request of the child's parent or physician.

By signing this form, the parent authorizes the school to administer medication only according to the guidelines as described below. Therefore, it is necessary that the parent gives a full and clear description of the medication procedure. Without clear directions, school personnel will not administer medication in any form. **School personnel will not administer medication based only upon the medication's label**.

Child's Name: ______________________________________ Name of Medication: _______________________________________

Prescribing Doctor's Name: _____________________________________ Prescribing Physician's Phone: _____________________

Dosage: __________________ Frequency:______________________________ Duration: _________________________________

Purpose of medication (ailment): ____

Additional Instructions: ____

____

❑ **School personnel are hereby given authority to dispense non-aspirin pain reliever to my child upon his or her request.**

I hereby authorize school personnel to administer medication as outlined above.

____ ____________________

Signature of Parent/Guardian Date