MEDICAL AUTHORIZATIONS
Parent Form

Student's Name (please print): _____ DOB: _____/_____/_____ Grade: _____

MEDICAL EMERGENCY TREATMENT AUTHORIZATION

EMERGENCY AUTHORIZATION: I hereby give permission to physicians and The New Community School representatives to examine, treat, hospitalize, and to order injection and/or anesthesia and/or surgery for the person named above. I/we authorize the release of medical information: (1) to New Community representatives (2) in an emergency, to the physician in charge of treatment. I acknowledge that the costs of transportation and treatment are entirely my own. Except as stated above, medical records are confidential and will not be released without my/our consent. A copy of this authorization shall be deemed as valid as the original. This authorization remains in effect until revoked in writing. I hereby release the personnel of the School and its trustees from any liability for these actions I have authorized.

_____ _____
1st Person to Contact — Relationship to Student

_____ _____
2nd Person to Contact — Relationship to Student

(_____)_____ (_____)_____
Home Phone — Work Phone

(_____)_____ (_____)_____
Home Phone — Work Phone

(_____)_____
Cell Phone

(_____)_____
Cell Phone

Preferred local hospitals: (1)_____

(2)_____

Insurance Company _____ Name of Insured _____ Policy # _____

_____ _____/_____/_____
*Parent/Guardian Signature — Date

PERTINENT MEDICAL INFORMATION

I give permission for pertinent medical information to be shared confidentially with members of the school faculty and staff as deemed appropriate to serve the best interests of my child.

_____ _____/_____/_____
*Parent/Guardian Signature — Date

OVER-THE-COUNTER MEDICATIONS PERMISSION

I ☐ Do ☐ Do Not give my child permission to take the following over-the-counter medications during the school hours or activities for headache, muscle aches, etc.:

Ibuprofen (Advil 200 mg. tablet or capsule)	☐ 1 tab	☐ 2 tabs	☐ Benedryl (dosage appropriate to age and weight)
Tylenol (325 mg. tabs)	☐ 1 tab	☐ 2 tabs	☐ Cough Drops
Tums (Regular Strength)	☐ 1 tab	☐ 2 tabs	

_____ _____/_____/_____
*Parent/Guardian Signature — Date

SPECIAL CONCERNS (Allergies, Ongoing Medications, Medical Issues, etc.)

Please note below any important medical information below including known allergies, medications, medical procedures, diet or physical restrictions, and **attach signed physician's orders for plan of care and treatment**. All medications including Epi Pens and Inhalers must be properly labeled with directions for use and the specific time of day to be administered.

*Entering your name in the parent/guardian signature field(s) on this form and emailing the completed form to the school will verify that you are signing this record as the parent or legal guardian of the child listed above. You may also choose to print the form, sign it, and return the original copy to the school.