

**THE BRANSON SCHOOL**  
**EMERGENCY INFORMATION FORM**  
**School Year 2011-2012 (DUE DATE 8/8/11)**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

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**EMERGENCY CONTACTS:** Authorized adults who should be contacted in case of emergency.

Parent or Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

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**PERSONS PERMITTED TO SIGN STUDENT OUT OF SCHOOL**

(Must be over 18 and not a Branson Student)

1. \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship

2. \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship

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**CONTACT INFORMATION FOR PHYSICIANS AND SPECIALISTS**

Primary Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

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**ATHLETIC PARTICIPATION**

**PARENTAL PERMISSION:** Must be filled out and signed by parent/guardian before student will be able to participate in school sports.

I/We consent to permit the above named student to compete in interscholastic athletics and travel to away competitions. I understand, acknowledge, and agree that the School, its employees, and/or volunteers shall not be liable for any and all potential risks, which may be associated with participation in such activities. I understand and acknowledge that participation in these activities are voluntary and not required by the School. I understand and acknowledge that injuries may occur during participation in these activities. In case the above named is injured, the coach or a school official is authorized to have him/her treated. I understand that I am responsible for all expenses and that accident insurance is not provided by The Branson School.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DOCTOR'S PERMISSION:** The following must be completed by a physician.

I hereby certify that I examined (student name) \_\_\_\_\_ on (date) \_\_\_\_\_ and he/she is physically able to participate in all athletics.

**Doctor's Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

(OVER)

**MEDICAL HISTORY:**

Please list any previous/ongoing injuries (including concussions/broken bones):

Please list any other health conditions (including depression/anxiety/insomnia):

Please list any known allergies (including food/environment):

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**ADMINISTRATION OF OTC MEDICATION DURING SCHOOL HOURS**

The employees of The Branson School are not trained medical professionals, but we are sometimes asked to assist students who are taking medications prescribed by a physician. Occasionally, a student requests over-the-counter (OTC) pain relief medication like Tylenol or Advil.

Prescription or OTC medication will only be administered by school personnel when the following steps have been completed:

1. Student's physician and parent/guardian have fully completed the appropriate sections of the "Administration of Medication During School Hours" form.
2. The prescription medication in the original container with the prescription label has been brought to school. (Parents may request an extra prescription container from the pharmacy for use at school to insure that the medication is properly labeled and is what the student's physician prescribed).
3. Parents have given the School explicit permission on the "Administration of Medication During School Hours" form to give a student Tylenol or Advil.

May your child be given pain relief medication during school hours? Please mark your response:

Tylenol       Yes       No  
Advil         Yes       No

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

My child does not take any prescribed medication and has no known health conditions.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*If your child takes a prescription medication or has known health conditions, please fill out both pages of the **ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS** form. \*\*\*

**The Branson School**  
**ADMINISTRATION OF PRESCRIBED MEDICATION DURING SCHOOL HOURS**  
School Year 2011-12

**(This Section To Be Completed By Student's Physician)**

Student \_\_\_\_\_ Grade \_\_\_\_\_

**TO THE STUDENT'S PHYSICIAN:** Please complete and sign the center section of this form when prescription medications must be given during school hours. This form is required by Section 11753.1 California Education Code, to authorize school personnel to assist the students with the administration of medication.

1. Date: \_\_\_\_\_

2. Diagnosis or reason for medication:

\_\_\_\_\_  
\_\_\_\_\_

3. Medication prescribed, strength, dosage, time to be taken:

\_\_\_\_\_  
\_\_\_\_\_

4. Inhaler prescribed, dosage, time to be taken:

\_\_\_\_\_  
\_\_\_\_\_

5. EpiPen prescribed, dosage, time to be taken:

\_\_\_\_\_  
\_\_\_\_\_

6. Any special instructions, precautions, or possible side effects:

\_\_\_\_\_  
\_\_\_\_\_

7. Additional Information and/or precautions regarding medications or student's conditions:

\_\_\_\_\_  
\_\_\_\_\_

I am a physician actively licensed by the State of California.

**Signature of Student's Physician:** \_\_\_\_\_

Print name of Physician: \_\_\_\_\_

Phone number of Physician: \_\_\_\_\_

**(Over)**

**(This Section To Be Completed By Parent/Guardian)**

STUDENT NAME: \_\_\_\_\_

**TO THE PARENT OR GUARDIAN:** The medication must be delivered to the school in the original pharmacy container.

**PLEASE SIGN THE FOLLOWING STATEMENT:** I am the parent/guardian of the above student and have lawful custody of said child. I hereby give consent to appropriate school personnel to administer or assist in administering medication and/or treatment as specified by his/her physician. **Please note: It is the parent’s responsibility to see that this form is updated as needed.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_

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**SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

\_\_\_\_\_ (student) has been instructed in the proper dosage and administration of the following medications: \_\_\_\_\_.

We/I (Parent/Guardian) request that she/he be permitted to carry this medication on her/his person and self-administer it as directed by our physician and in compliance with school policy and procedures.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I certify that I have read and understand the instructions regarding the self-administration of my medication(s). I agree to take these above described medications in compliance with my physician’s recommendation.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Attention Parent/Guardian: Please read if your child takes daily prescription medicine**

In the event of an emergency or disaster, students may be required to stay at school for an extended period of time. For this reason it is essential that those students who require daily medications keep a 72-hour supply at their school site. Examples of medications which should not be abruptly stopped include those used to treat diabetes, epilepsy or seizures, asthma, cardiac problems, depression, anxiety, allergic reactions and any other chronic problems.

The following steps should be taken: (1) Obtain an authorization to administer medication from school (2) Physician and parent must both sign the form indicating the dose, frequency and the side effects. (3) Send in a 72-hour supply of medication in an original prescription container along with completed authorization form. (4) Please place it in a quart sized zip lock bag labeled with your child’s name and advisor. (5) Replacement medications will be due in October every year. If any medication changes occur, please contact the receptionist.