Munster Robotics Club
Munster Horsepower Team 3147
Consent for Emergency Treatment

Name: _____ Date: _____

Address: _____

Home Phone: _____

Mother's Phone: _____

Father's Phone: _____

First Emergency Contact: _____

Second Emergency Contact: _____

In case _____ (student's name) becomes ill, I _____ (parent/guardian name) give permission to an agent or employee of the School Town of Munster to take the following course of action in the event of a medical emergency:

1- Administer first aid
2- If thought necessary or serious:
    a. To be seen by a physician in office
    b. Admit to emergency room of hospital
    c. Admit to hospital if recommended by physician
3- Notify parent or guardian as soon as reasonably possible.

Please make notations in the space below if the above steps are found unsatisfactory for personal or religious reasons. If unsatisfactory, please give alternate instructions for treatment.

_____ _____

Signature of parent/guardian Date

Munster Robotics Club
Munster Horsepower Team 3147
Medical Information

Name: _____ DOB: _____

Exact date, if possible, of last tetanus shot: _____

Specific diseases, such as diabetes, heart disease, etc, medical problems for which the student is presently being treated or medical history of which the teacher should be aware:

_____

_____

Attach additional pages if needed.

Allergies to medication: _____

Allergies to foods: _____

Special diet foods: _____

All prescriptions must be in prescription bottles with the original labels giving the student as the patient. The name and dosage of the medications must be included on the label. The precise drug information should be included, if possible.

What medication will the student be carrying? _____

What is it for? _____

When are you to take it? _____

Attach additional pages if needed.

Will the student be wearing contact lenses? YES _____ NO _____

Parent or Guardian Signature _____ Date _____

Munster Robotics Club
Munster Horsepower Team 3147
Authorization for Nonprescription Medications

Name: _____ Date: _____

Address: _____

Home Phone: _____

Mother's Phone: _____

Father's Phone: _____

I/We, the parent(s)/guardian(s) of _____ (name of student) request, authorize and give permission to the club advisor/directors, to administer the medication below in accordance with the instructions provided. We agree to notify the school of any change in circumstances concerning the administration of this medication.

MEDICATIONS: Acetamenophen, Ibuprophen, Benadryl, Benadryl Cream, Eye Drops, Neosporin, or other over-the-counter medication deemed appropriate for minor conditions or injuries.

DOSAGE: Per package directions

FREQUENCY: Per package directions

SYMPTOMS OF: Headaches, insect bites, pain for minor injury, minor eye irritation, prevention of /or infection from minor injury or any other minor condition

OVER-THE-COUNTER Medications you desire for your student other than those listed above. (please provide to coach in a sealed, LABELED container.)

_____

_____

List any over-the-counter medications your child should **NOT** use because of allergy or any other reason.

_____

_____

_____ _____

Signature Date