

# SOUTH CENTRAL NEBRASKA USD#5

FORM: MEDICAL, MEDICATION & EMERGENCY TREATMENT  
 COMPLETED BY: All students (K-12) must complete this form and return to the office.

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

**MEDICAL PROVIDER SUMMARY:** Please complete the following.

HEALTH INSURANCE PROVIDER	HEALTH INSURANCE POLICY #	
STUDENT'S MEDICAL PROVIDER(S)	Provides Care for	Phone Number

**SUMMER HEALTH SUMMARY:** Please complete the following.

- **Vision:** Did student get new glasses or contacts? \_\_\_\_ YES \_\_\_\_ NO
- **Dental:** Check up date: \_\_\_\_\_ Dentist's name: \_\_\_\_\_
- **Vaccination(s):** Please list names and dates received of any immunizations received over the summer

NAME OF VACCINATION	DATE RECEIVED

**MEDICATION(S):** Please complete the following.

NAME OF MEDICATION	Beginning Date of Administration	Dosage (Amount)	Method of Administration	Time of Administration

- Is the student on any medication that we need to be aware of to watch for side effects? \_\_\_\_ YES \_\_\_\_ NO
- Side effects to watch out for: \_\_\_\_\_

**ALLERGIES:** Please complete the following if applicable.

- Food or other allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Medication allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

**PERMISSION TO ADMINISTER TYLENOL:** Check the following that applies to your student.

- \_\_\_\_ YES, I give permission for South Central Nebraska USD#5 to administer Tylenol to the student listed above.  
 \_\_\_\_ NO, I DO NOT give permission for South Central Nebraska USD #5 to administer Tylenol to the student listed above.

**DIRECTIONS:** \* 7th-12th Grade Only - Please fill out the EMERGENCY TREATMENT AUTHORIZATION section below if you wish to have your child treated in case of an emergency. It is our understanding that South Central Nebraska USD#5 (SCNUSD#5), affiliated schools, it's athletic department and it's Board of Education will not assume responsibility or obligation for any medical bills or debts resulting from any injury to the above mentions student(s) while practicing or playing in any practice session, scrimmage or contest. I also understand that my student(s) must be covered by health insurance before he/she will be allowed to participate in any sports. My child(ren) is/are covered in the following manner:

- \_\_\_\_ NO, student(s) IS NOT COVERED by any health insurance provider.  
 \_\_\_\_ YES, We WILL purchase the necessary insurance provided by the school to cover our athlete, prior to the first day of practice.  
 \_\_\_\_ NO, We DO NOT wish to purchase insurance and we MUST contact the superintendent if we DO NOT wish to purchase insurance.  
 \_\_\_\_ YES, student(s) IS COVERED by the following insurance provider: \_\_\_\_\_ POLICY #: \_\_\_\_\_

I, the parent/guardian(s) of \_\_\_\_\_ hereby request the release of this form to SCNUSD#5. If during an away activity, emergency services involving medication, action and treatment are indicated and the parent/guardian(s) cannot be reached, the parent/guardian(s) hereby consent(s) to the rendering of such emergency medical services for the above named student by the medical provider on duty at the nearest hospital.

**ELIGIBILITY INFORMATION:** In order to represent SCNUSD#5 in interscholastic athletic competition, a student must abide by the eligibility rules of SCNUSD#5 and Nebraska School Activities Association (NSAA). If you have any questions concerning SCNUSD#5 for student/athlete or those rules set by the NSAA, please do not hesitate to contact the school's administration or athletic director at 225-3371 (Lawrence/Nelson) or 726-2151 (Sandy Creek).

**PARENT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_