PAYSON UNIFIED SCHOOL DISTRICT
CONSENT TO MEDICAL TREATMENT

Campus: _____ School Year: _____ Grade:_____

Student Name: _____ Date of Birth:_____ Sex: ☐ M ☐ F

Physical Address: _____ Mailing Address: _____

Mother's Name: _____ Father's Name:_____

Home #: _____ Home#: _____

Work#: _____ Work#: _____

Cell#: _____ Cell#: _____

Two emergency contacts other then parent/guardian are required

1. Name: _____ Relation: _____ Phone: _____ Okay to pick up? ☐ Y ☐ N

2. Name: _____ Relation: _____ Phone: _____ Okay to pick up? ☐ Y ☐ N

Local Doctor: _____ Phone: _____ Okay to contact? ☐ Y ☐ N

CONSENT TO MEDICAL TREATMENT

I, _____, am the natural parent or legal guardian of _____ a minor student, age _____. I authorize assigned certificated staff or appointed designee, in the Payson Unified School District #10, State of Arizona, to consent to any X-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care, to be rendered to the student under the general or special supervision and on the advice of any licensed physician or surgeon, <u>when the need for such treatment is clear and when efforts to contact me are unsuccessful.</u> If it is necessary to call 911 to transport your child to the hospital the school is authorized to do so.

X Parent Signature: _____ Date: _____

During the course of the school year we often find it advisable to use ingested or topical medications in the treatment of minor injuries or illnesses. A few such conditions are sore throats, cough, headaches, stomach aches, scratches, blisters, etc. Arizona State law prohibits us from treating any conditions without written consent from the parent. <u>The administration of PRESCRIPTION drugs requires the written permission of the parent.</u> Forms are available from your school's Health Specialist.

The products or their generic equivalent that we use most often in the Payson Schools are listed below. If you **<u>DO NOT</u>** want your child to receive the benefit of any product listed below, please check that particular medication.

- ☐ ACETAMINOPHEN (Tylenol, Equate, etc)
- ☐ ANTIHISTAMINE
- ☐ ALCOHOL (Topical)
- ☐ ANTACID
- ☐ ANTIBIOTIC OINT/CREAM
- ☐ AMBESOL/ORAJEL
- ☐ CALADRYL LOTION
- ☐ CAMPHOPHENIQUE
- ☐ CARMEX
- ☐ CORTISONE CREAM
- ☐ COUGH DROPS/LOZENGES
- ☐ DERMA PLAST
- ☐ EYE WASH/ DROPS
- ☐ HYDROGEN PEROXIDE
- ☐ IBUPROPHEN
- ☐ MIDOL
- ☐ SOLARCAINE
- ☐ SORE THROAT SPRAY
- ☐ SPORTSCREAM
- ☐ UNGENTINE (Burns)
- ☐ VASELINE

Please list any ALLERGIES your child may have to these or any other medications: _____

Current medications and dose: _____

ANY SPECIAL MEDICAL NEEDS / DIAGNOSIS: _____

_____

I hereby give permission for my child to receive any of the ingested or topical medications listed above.

X Parent Signature: _____ Date: _____

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