

Family Name: _____

ECS Medical Treatment Release

Physician:	Phone:
Street Address:	City, State, Zip:

Please list name(s) of all child(ren) this form applies to:

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RELEASE FOR EMERGENCY MEDICAL TREATMENT

I (we) the parent(s) of: _____ a student(s) at Elyria Christian School, hereby authorize the school staff to perform or procure whatever emergency medical treatment is deemed necessary for the assistance of my child(ren). This may include transportation to a local hospital or summoning emergency medical help to the school premises or offsite school events. Although every effort will be made to contact me as soon as possible, I agree that the above emergency measures may be performed prior to my knowledge and that I assume full responsibility for any financial liability thereof.

Signature of Parent or Guardian

Date

Over the Counter or Nonprescription Medication:

(Please mark any medications (generic brand) your child may take at school.)

Medication:	Child Name:	Child Name:	Child Name:	Child Name:
Antacid (Tums)				
Ibuprofen (Advil)				
Acetaminophen (Tylenol)				
Antihistamine (Allergy relief)				
Cough Drop				

I hereby **DO / DO NOT (Circle one)** give my permission for above named child(ren) to take the above medication(s) at school as noted above. I understand that it is my responsibility to furnish prescription medications. I further understand that any school employee who administers any drug to my child/student in accordance with written instructions from the physician, dentist, or myself shall not be liable for damages as a result of an adverse drug reaction suffered by my child/student because of administering such drug.

Signature of Parent or Guardian

Date