

HENDERSON I.S.D.
201902

WELLNESS AND HEALTH SERVICES
MEDICAL TREATMENT

FFAC
(EXHIBITS)

The following exhibits may be used for medical treatment in the District:

Exhibit A: Request for the Administration of Medication at School — 1 page

Exhibit B: Authorization for Emergency Medical Treatment — 1 page

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MEDICAL TREATMENT

FFAC
(EXHIBITS)

HENDERSON INDEPENDENT SCHOOL DISTRICT
REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Henderson Independent School District has my permission to administer the
medication _____ to my child
(Medication/Dosage)

_____. This medication is being
(Child's Name)

given for _____.
(Illness/Condition)

This medication needs to be given at the following times:

1. _____
2. _____
3. _____
4. _____

SPECIAL INSTRUCTIONS:

(Signature of Parent/Guardian) _____
(Date)

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WELLNESS AND HEALTH SERVICES
MEDICAL TREATMENT

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(EXHIBITS)

HENDERSON INDEPENDENT SCHOOL DISTRICT
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student Name: _____ DOB: _____ Phone: _____

Address: _____

Physicians Name: _____ Medical Facility: _____

Health Insurance Co: _____ Policy # _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury at school and/or on a school-sponsored trip, I authorize Henderson ISD personnel to secure and retain medical treatment and transportation if needed and/or release student records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed life saving by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury at school and/or on a school-sponsored trip.
In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____
Parent or Legal Guardian