Emergency Medical Authorization

Student's Name _____ DOB _____
Home Address _____
City_____ State_____ Zip_____ Phone_____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian
Mother's Name_____ Home/Cell# _____
Work # _____ Email _____

Father's Name _____ Home/Cell# _____
Work # _____ Email_____

Other's Name _____ Home/Cell# _____
Relationship _____ Work # _____
Email _____

PART I OR II MUST BE COMPLETED

PART I – To Grant Consent
I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____
Dentist _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby consent for
(1) the administration of any treatment deemed necessary by above named Doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and
(2) transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

SIGNATURE OF PARENT OR GUARDIAN REQUIRED TO GRANT CONSENT

Signature _____ **Date** _____

PART II – Refusal to Consent
I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take the following action:

_____
_____
_____

SIGNATURE OF PARENT OR GUARDIAN REQUIRED for REFUSAL TO CONSENT

Signature _____ **Date** _____

Please complete reverse side…

Student Health History

Student Name:

I. Health Conditions. Please check any that this child has had**:** ☐ **NONE**

- ❑ Abnormal Spinal curvature (scoliosis, etc)
- ❑ ADD/ADHD
- ❑ Allergies or hayfever
- ❑ Anemia
- ❑ Asthma or wheezing
- ❑ Bedwetting at night
- ❑ Behavior problem
- ❑ Birth or congenital malformation
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Chronic diarrhea or constipation
- ❑ Concern about relation with siblings or friends
- ❑ Cystic fibrosis
- ▢ Diabetes/Mumps
- ▢ Eczema
- ▢ Emotional
- ▢ Ear problems
- ▢ Eye problems
- ▢ Frequent headaches
- ▢ Frequent skin infections
- ▢ Frequent sore throat
- ▢ Heart
- ▢ Hepatitis
- ▢ Kidney disease
- ▢ Measles (*"old fashioned"* or *"10 day"*)
- ▢ Meningitis or encephalitis
- ▢ Other
- ▢ Near-drowning or near suffocation
- ▢ Nervous twitches or tics
- ▢ Poisoning
- ▢ Rubella (3 day measles)
- ▢ Rheumatic fever
- ▢ Seizure or epilepsy
- ▢ Sickle cell disease
- ▢ Stool soiling
- ▢ Suicide attempt
- ▢ Positive TB test
- ▢ Toothaches or dental infections
- ▢ urinary tract infection
- ▢ Wetting during the day

***Please explain any checked item:**

II. Injuries and Illnesses. Please list any severe injuries or illnesses: ▢ **NONE**

Injuries/Illnesses	**Age of Child**	**Hospitalized (yes or no)**
_____		

III. Allergies. Please list and describe allergies or reactions: ▢ **NONE**

Medicines/Drugs*
Foods/Plants/Animals/Other
Recommended treatment if allergy is severe
List any emergency medication your child requires (epi-pen, inhaler, etc.)

**Please complete and have your doctor sign Medication Administration Form, available online or at school office.*

IV. Additional Information

What medications are given daily? _____ ▢ **NONE**
What medications are given frequently, but not daily? _____
This child is usually: _____ very active _____ normally active _____ rather inactive
Is your child under medical treatment at present? YES or NO (*Circle one*)
If yes: Reason _____
Physician: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

V. To my knowledge, above information is current and accurate.

Parent signature _____ Date _____

VI. ATTACH CURRENT IMMUNIZATION OR EXEMPTION FORM, SIGNED BY DOCTOR.
State law requires that immunization forms for each student be on file at school within 30 days of the first day of school, or school attendance will not be permitted.

VII. PRESCHOOL AND PREKINDERGARTEN STUDENTS – COMPLETE AND ATTACH PHYSICAL EXAM FORM (attached). State law requires that preschool and prekindergarten students have a physical exam within six months prior to the first day of school, and that the attached form be on school file within 30 days of the first day of school, or school attendance will not be permitted.