



EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

Student's Full Legal Name _____ Grade _____

Student's **Mailing** Address _____

Student's **Physical** Address _____

Student's Home Phone Number _____ Student's Birth Date _____ Age _____

Mother's Full Name _____ Work/cell number _____

Father's Full Name _____ Work/cell number _____

Guardian _____ Work/cell number _____

Student lives with _____

Email address of Parent/Guardian _____

ALTERNATE EMERGENCY CONTACTS (Local people 18 years or older to contact if parent can't be reached)

1. Name _____ Relation _____ Phone _____

2. Name _____ Relation _____ Phone _____

3. Name _____ Relation _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber's Name _____

ID or Group Number _____

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary.

Doctor _____ Phone number _____

Dentist _____ Phone number _____

Hospital _____ Phone number _____

If for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY TO WHICH THE SCHOOL NURSE SHOULD BE ALERTED

Student Name _____ Grade _____

**Please indicate if student has had or is currently receiving medication for any of the following conditions:
Give year or age when problem occurred.**

<u>CONDITION</u>	<u>DATE/DATES OF OCCURENCE</u>
____ Vision problems, glasses/contacts	_____
____ Asthma	_____
____ Uses inhaler	_____
____ Diabetes	_____
____ Ear/Hearing problems	_____
____ Emotional problems	_____
____ Seizures	_____
____ Heart Problems	_____
____ Hepatitis	_____
____ Meningitis	_____
____ Migraines	_____
____ Muscular weakness	_____
____ Bleeding disorders	_____
____ High blood pressure	_____
____ Infectious disease	_____
____ Last tetanus shot	_____
____ Seasonal allergies	_____
____ Environmental allergies	_____
____ Allergic reactions	_____
____ Disability	_____
____ Hospitalized for serious illness, Surgery or Accident	_____