STUDENT EMERGENCY MEDICAL AUTHORIZATION FORM

Please type or print using a ballpoint pen when completing this form. This form must be completed annually and returned to the school as soon as possible.

Student Name _____ Date of Birth _____ Grade _____

Address _____ Telephone _____

_____

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.

Mother's Name _____ Cell Phone _____

Father's Name _____ Cell Phone _____

Other's Name _____ Phone _____

COMPLETE ONLY PART 1 OR PART 2

PART 1: TO GRANT CONSENT:

Doctor _____ Phone _____

Dentist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the 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 of such surgery, are obtained prior to the performance of surgery.

IMPORTANT: Facts concerning the child's medical history, including allergies, medications being taken, any physical impairments to which a physician should be alerted are on the reverse side.

Signature of Parent/Guardian _____ Date _____

PART 2: TO REFUSE CONSENT:
I do not give my consent for emergency medical treatment to my child. In the event of illness or injury requiring emergency treatment, I will the school authorities to take the following action:

_____

Signature of Parent/Guardian _____ Date _____

Adults, other than mother or father, who have permission to pick up your child:

1. _____ Phone _____ Relationship _____
2. _____ Phone _____ Relationship _____
3. _____ Phone _____ Relationship _____
4. _____ Phone _____ Relationship _____
5. _____ Phone _____ Relationship _____

The following individuals MAY NOT pick up my child: Custody restrictions require documents to be on file in the main office.

1. _____ Phone _____ Relationship _____
2. _____ Phone _____ Relationship _____

Will this student be attending After Care for any length of time on any school day? Yes No

HEALTH INFORMATION INVENTORY

Your child's learning depends upon good health. Please complete this form with information you are comfortable sharing. Health conditions currently affecting your child are of the greatest significance.

Bee Sting Allergy? Yes No Describe reaction _____
Difficulty breathing? Yes No Emergency medication? Yes No
Comments _____

Peanut Allergy? Yes No Describe reaction _____
Difficulty breathing? Yes No Emergency medication? Yes No
Do you eliminate all peanut-containing foods? Yes No
Comments _____

Other Food Allergy? Yes No Food _____ Describe reaction _____
Difficulty breathing? Yes No Emergency medication? Yes No
Comments _____

Other Allergy? Yes No Allergy _____
Describe reaction _____
Any Medications needed? _____
Comments _____

Asthma? Yes No Triggered by: _____ Treatment _____

Diabetes? Yes No Type I _____ Type II _____
Takes Insulin? Yes No Insulin Pump? Yes No
Comments _____

Epilepsy/Seizures? Yes No Comments _____

Heart Condition? Yes No Comments _____
Activity restrictions? _____

Please circle the following regarding health concerns that pertain to the student:

Eyes: Glasses: reading distance contacts lazy eye crossed difficulty seeing
Ears: frequent infections tubes hearing difficulty
Hearing Aid: right left

Other: ADD/ADHD bladder blood-disorder menstruation anxiety blood pressure
neurological bi-polar breathing nosebleeds depression headaches

Daily medication: At home? Yes No At school? Yes No Emergency only? Yes No

Name of Medication _____ Reason for taking _____

Medication Information:

A. It is strongly recommended to parent, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.
B. If this is not possible, the Medication Request and Authorization must be filed with the main office before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted on an annual basis.
C. Each prescribed medication, in the original container, shall have a pharmacist's label.
D. Any unused medication unclaimed by the parent will be destroyed by school personnel when a prescription is no longer to be administered or at the end of the school year.

Condition that prevents or limits Physical Education (P.E.) participation _____

The space below is provided for you to list any additional information concerning your child's health or medical conditions of which the school staff should be aware.

_____

_____

Note: Your child's health and education are very important to us. The above information will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his/her well being. Confidentiality will be maintained and the information will be shared with those responsible for the sole purpose of meeting the care and custody of the child's medical needs.