EMERGENCY MEDICAL AUTHORIZATION FORM Page 1 of 2

Purpose: To authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. This form may be used to identify the medical options of the undersigned parent. MEDICAL INFORMATION IS **CONFIDENTIAL AND HELD BY OUR HEAD OF SCHOOL. PLEASE WRITE CLEARLY IN BLACK INK**

Student's Name First _____ Middle: _____ Last: _____

Date of Birth / / F / M (circle) Grade _____

Student's cell phone # _____ Student's email _____

Mother First Name _____ Last Name:_____
Address _____Apt#_____
City: _____ State: _____ Zip: _____

Home Phone _____Work Phone _____Cell Phone_____
Email _____

Employer _____

Father First Name_____ Last Name _____

Address _____Apt#_____

City:_____ State:_____ Zip: _____

Home Phone _____Work Phone _____Cell Phone_____

Email _____

Employer _____

Two emergency contacts other than listed above (stepparent, grandparent, trusted family friend, etc.)

First Name_____ Last Name _____
Address_____ City _____
Home Phone _____ Work Phone _____ Cell Phone _____
Relationship to student: _____

First Name _____ Last Name _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone_____
Relationship to student _____

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STUDENT'S NAME First _____ Last _____ Grade_____

MEDICAL HISTORY AND CONDITIONS: Please indicate if your child has had, or is currently under, treatment for any of the following conditions. Please give description and date of illness or medical issue to which emergency medical personnel and the school nurse should be alerted:

ASTHMA_____
ALLERGIES_____
BLEEDING DISORDER _____
DIABETES_____
EAR/HEARING PROBLEM_____
EMOTIONAL PROBLEM_____
HEART PROBLEMS_____
HEPATITIS_____
HIGH BLOOD PRESSURE_____
INFECTIOUS DISEASES_____
MENINGITIS_____
MIGRAINE HEADACHES_____
MUSCULAR WEAKNESS/PARALYSIS:_____
SEIZURES_____

REACTIONS TO ANY MEDICATION OR VACCINATION _____

CURRENT OR LONG TERM MEDICATIONS (please list) _____

ANY HOSPITALIZATION, SERIOUS ILLNESS OR ACCIDENT _____

CONTACT LENSES? Yes / No EYE PROBLEMS _____ DATE OF LAST TETANUS SHOT _____
HAVE YOU EVER BEEN INFORMED OF THE NEED FOR AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT? Yes / No

FURTHER DETAILS OR MEDICAL ISSUES NOT INCLUDED ABOVE (use back of page if needed)

§504 Disclosure of Disability: I believe that my child may have a disability that qualifies him/her for §504 accommodations and I request a review of his/her case. Suspected Disability: _____

INSURANCE or MEDICAID INFORMATION Check if no insurance _____
Insurance company _____ ID # _____ Under which parent's name? _____

TO GRANT CONSENT IN CASE OF EMERGENCY
In case of 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: _____
Dentist _____ Phone: _____
Nurse Practitioner/Physician Assist_____ Phone: _____
Hospital _____ Phone: _____

If, for any reason, the 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 concur 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.

Parent/Guardian Printed Name _____

Signature _____Date: _____