

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.

School District	School Building	Home Room Teacher	Grade
Student's Full Name _____			
Last	First	Middle	Social Security #
Student's Address _____			
Street/Road	P.O. Box/Apt #	City	Zip Code
Student's Birth Date _____		Telephone () _____	
Mother's Full Name _____		Daytime Phone () _____	
Father's Full Name _____		Daytime Phone () _____	
Guardian or Child Care Provider _____		Daytime Phone () _____	
Guardian or Child Care Provider's Address _____			
Street/Road	P.O. Box/Apt #	City	Zip

ALTERNATE EMERGENCY CONTACTS (Local people to contact if parents cannot be reached)

1. Name _____ Phone _____ 2. Name _____ Phone _____

INSURANCE INFORMATION
Student's Insurance _____ Subscriber's Name _____ ID Number _____ (primary)

TO GRANT CONSENT

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 () _____
Dentist _____	Phone () _____
Nurse Practitioner/Physician Assistant _____	Phone () _____
Hospital _____	Phone () _____

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 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.

Signature of Parent/Guardian _____ Date _____

**FACTS CONCERNING THE CHILD'S MEDICAL HISTORY
TO WHICH A PHYSICIAN SHOULD BE ALERTED**

Please indicate if student has had or is currently under treatment for any of the following conditions:

Give year or age when problem occurred.

ASTHMA
 DIABETES
 EAR/HEARING PROBLEMS: (type) _____
 EMOTIONAL PROBLEMS: (type) _____
 SEIZURES
 HEART PROBLEMS: (type) _____
 HEPATITIS: (type) _____
 OTHER: _____

MENINGITIS
 MIGRAINE HEADACHES
 MUSCULAR WEAKNESS OR PARALYSIS
 BLEEDING DISORDERS: (type) _____
 HIGH BLOOD PRESSURE
 INFECTIOUS DISEASES: (type) _____
 TETANUS SHOT: (date) _____

ALLERGIES?

REACTIONS TO MEDICINE OR INJECTIONS? _____

HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS? _____

USE OF CONTACT LENSES? YES _____ NO _____

LONG TERM MEDICATIONS? _____

HAVE YOU EVER BEEN INFORMED OF THE NEED TO BE ON ANTIBIOTIC THERAPY PRIOR TO DENTAL TREATMENT? YES _____ NO _____
IF YES, IDENTIFY REQUIRED THERAPY _____

PLEASE ADD ANY PROBLEMS NOT LISTED _____

Notes: