Elder High School
EMERGENCY MEDICAL AUTHORIZATION

DUE NO LATER THAN 6/1/18
2 sided form

Student:	Date of Birth:	Grade:	School Year: **2018-2019**
Address:	City:	State:	Zip:
Home Phone Number:	Student Cell Phone Number:		

A. Residential Parent or Guardian

Mother's Name: Email:	Daytime Phone Number:
	Cell Phone Number:
Father's Name: Email:	Daytime Phone Number:
	Cell Phone Number:
Other Name/Relationship:	Other Daytime Phone Number:
	Cell Phone Number:

B. Name of Relative or Childcare Provider (to be notified if unable to reach parent/guardian)

	Name	Relationship to Student	Daytime Address	Preferred Phone Number
1				
2				

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

***** PART I **OR** PART II MUST BE COMPLETED AND SIGNED ******

PART I – **TO GRANT CONSENT** I hereby give consent for the following medical care providers and local hospital to be called.

Doctor's Name:	Phone Number:
Dentist's Name:	Phone Number:
Medical Specialist:	Phone Number:
Local Hospital:	Phone Number:
Insurance Company:	Insurance Policy Number:

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 doctor, 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 for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician and/or school personnel should be alerted:

Signature of Parent/Guardian:	Date:
Address:	

PART II – **REFUSAL TO CONSENT** (DO **NOT** COMPLETE PART II IF YOU COMPLETED PART I)

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian:	Date:
Address:	

OVER

Student: ____

Allergies:

Life Threating to:	**Epinephrine Prescribed:** □ **Yes** □ **No**
Medication(s) to:	
Seasonal to:	

Injuries, Illnesses, Hospitalizations & Surgeries:

Type	Age	Explain

Immunizations: Please provide the date (month/day/year) of last Tetanus shot: ________________________________
Date required for Athletes

Medication Information: Please describe any medications that your child takes daily and frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken?	What time is the medication taken?

Does student wear medical alert identification? □ **Yes** □ **No** **If yes, explain:**______________________________

Health Conditions: Check any medical condition that the student currently has or has had in the past.

- □ Asthma-Trigger(s) ___________________
  Has your child ever needed emergency treatment for asthma? □ Yes □ No
- □ ADD/ADHD
- □ Behavior concern
  Explain: __________________________
- □ Birth or congenital malformation
  Explain: ___________________________
- □ Bladder/Bowel Problems
  Explain _______________________
- □ Bleeding Disorder
  Explain: ________________________
- □ Blood Pressure Problems (High/Low)
  Explain: ___________________________
- □ Cancer
  Explain: ____________________________
- □ Chronic ear infections (frequent after age of 3)
  Currently under medical care? □ Yes □ No
  Currently has PE tubes? □ Yes □ No
- □ Cystic Fibrosis
- □ Depression
- □ Diabetes Age of diagnosis ________________
- □ Eating Disorder
- □ Eczema/Chronic skin conditions
  Explain: _______________________________
- □ Emotional Concerns
  Explain _______________________________
- □ Eye problems, poor vision
  Explain _______________________________
  Wears glasses/contacts? □ Yes □ No
  Date of last eye exam _____________________
- □ Fainting
- □ Headaches (frequent) □ Migranes
- □ Hearing problems
  Explain: _____________________________
  Wears hearing aid? □ Yes □ No
  Date of last hearing exam _______________
- □ Heart Condition
  Explain: _____________________________
- □ Kidney Disease
  Explain: _____________________________
- □ Nervous twitches/tics
- □ Seizure disorder/Epilepsy
  Date of last episode ____________________
- □ Sickle Cell Disease (not trait)
  Date of last sickle cell crisis: ____________
- □ Identify any other health information that you believe school personnel need to be aware of:
  ____

□ **None of this information applies to student.**

Add any comments or concerns you have about your student's health, development, behavior, family, or home life that you would like the school to be aware of:

This information may be shared with school personnel in order to provide for your child's health, safety and educational programming. In addition, a copy of this form may be provided to athletics, employees and/or chaperones for student participation in sports and/or a field trip.

Parent/Guardian Signature ____ **Date** ___________________________