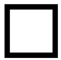
HEALTH ALERT 

EMERGENCY MEDICAL AUTHORIZATION

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. This information may be shared with the educational team to best meet your child's needs.

Student Name ___________________________________ Phone # _______________________ Bus # _______
Address ____ School District _______________________________
____ School Attending _____________________________
Address Change Y N Birth Date ________________ Sex M F Grade _________ Home Room ________

Residential Parent or Guardian: ****Email:** ____

Mother ____________________________ Day Ph # ____________________ Cell # __________________________

Father ____________________________ Day Ph # ____________________ Cell # __________________________

Other Contact ___________________________ Relationship __________________ Ph # ______________________

Other Contact ___________________________ Relationship __________________ Ph # ______________________

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ____ Phone # ____
Dentist ____ Phone # ____
Medical Specialist _________________________________ Phone # ____
Hospital ____ Phone # ____

Check below any *CURRENT* health condition that may require attention during the school day:

- ☐ Allergies (be specific)
  - ☐ Food _________________ **EpiPen ___Yes ___No**
  - ☐ Medicine _________________________________
  - ☐ Bee sting **EpiPen ___Yes ___No**
  - ☐ Other ____________________________________
- ☐ Asthma **Uses emergency inhaler ___Yes ___No**
  Inhaler will be at school ___ Yes ___No
- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Heart problems (be specific) ______________________
  ____
- ☐ Physical disability (be specific) __________________
  ____
- ☐ Other health conditions (be specific) _______________
  ____
- ☐ Previous surgeries (include date) __________________
  ____
- ☐ Previous concussion/head injury – year ____________
- ☐ Hearing problems Has hearing aids ___Yes ___No
- ☐ Vision problems (be specific) ____________________
  ____
  Wears: ☐ Glasses ☐ Contacts
- ☐ ADHD
- ☐ Behavior/emotional problems____________________
  ____
- ☐ Bleeding Disorder
- ☐ **NO CURRENT HEALTH CONDITIONS**

☐ **List all medications and dosages your child receives on a continual basis:**____
____

PLEASE COMPLETE PART I *OR* PART II – NOT BOTH

Part I – TO GRANT CONSENT
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 the designated physician or dentists, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date_____________ **Parent or Guardian Signature**________________________________

Part II – REFUSAL TO CONSENT
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 no action or to: ____
____

Date_____________ Parent or Guardian **REFUSAL** Signature________________________________