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_____