Rev 3-09

EMERGENCY MEDICAL AUTHORIZATION

Health Alert ☐

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_____ Homeroom_____

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Residential Parent or Guardian

Mother _____ Day Phone #_____ Cell # _____
Email _____ Pager # _____
Father _____ Day Phone # _____ Cell # _____
Email _____ Pager # _____
Other Name _____ Day Phone # _____ Cell # _____
Name of Relative/Childcare Provider _____
Address _____Phone # _____
_____Relationship _____

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

Doctor _____ Address_____ Phone # _____
Dentist _____ Address _____ Phone # _____
Medical Specialist _____ Phone # _____
Hospital _____ Phone # _____

Below check any current health condition that may require attention during the school day:

☐ Allergies (be specific)
- ☐ Foods _____
- ☐ Medicines _____
- ☐ Bee sting _____
- ☐ Other _____

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Hearing problems ☐ Hearing aid(s)
☐ Heart problems (be specific) _____
_____
☐ Surgeries _____
_____

☐ Concussion/head injury – year _____
☐ Physical disability (be specific) _____
_____
☐ Respiratory (be specific) _____
_____
☐ Seizures
☐ Vision problems (be specific)_____
_____
☐ Glasses ☐ Contacts
☐ ADD/ADHD
☐ Behavior/emotional problems _____
_____
☐ Other (be specific) _____

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.

The 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 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 _____