CENTRAL CATHOLIC HIGH SCHOOL 2023-2024

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: Central Catholic High School
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_____

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Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You cannot see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

• Headaches	• Amnesia
• Pressure in head	• "Don't feel right"
• Nausea or vomiting	• Fatigue or low energy
• Neck pain	• Sadness
• Balance problems or dizziness	• Nervousness or anxiety
• Blurred, double, or fuzzy vision	• Irritability
• Sensitivity to light or noise	• More emotional
• Feeling sluggish or slowed down	• Confusion
• Feeling foggy or groggy	• Concentration or memory problems (forgetting game plays)
• Drowsiness / Change in sleep pattern	• Repeating the same question/comment

Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions.

Student

Student Name (Print): _____ Grade: _____

Student Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Signature: _____ Date: _____

Relationship to Student: _____