CONFIDENTIAL

SCHOOL _____

Rm.# _____ Grade _____

Date _____

EMERGENCY MEDICAL AUTHORIZATION

Please complete this form in **blue** or **black** ink only.

Student name _____ D.O.B. _____
Last First Mid

Address _____ Home Phone # _____
Street City Zip

Cell # _____

MEDICAL HISTORY

	YES	NO
Diabetes:	_____	_____
Insulin Dependent	_____	_____
Oral Medications	_____	_____
Epilepsy:	_____	_____
Medication	_____	_____
Hearing:	_____	_____
Hearing Aides	_____	_____
Heart Disease:	_____	_____
Orthopedics:	_____	_____
Assisted Aides	_____	_____
Asthma:	_____	_____
Inhaler/Nebulizer	_____	_____
ADD:	_____	_____
Medication	_____	_____

	YES	NO
ADHDs:	_____	_____
Medications	_____	_____
Vision:	_____	_____
Glasses	_____	_____
Allergies:	_____	_____
Medications	_____	_____
_____	_____	_____
Environmental:	_____	_____
_____	_____	_____
Bee Sting:	_____	_____
_____	_____	_____
Food:	_____	_____
_____	_____	_____

If any of the above are checked, please explain: _____

_____

_____

_____

MEDICATION: Name / Type and Use _____

_____

_____

If your child is allergic to bees, what symptoms does he/she have after being stung and what action needs to be done?

_____

_____

Is medication prescribed? _____

(Over)

Student name _____
Last First Mid

Statement regarding consent when contact of parent(s) is unsuccessful: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctor/dentist, or in the event the designated preferred practitioner is not available, by another licensed physician/dentist and (2) the transfer of the child to any hospital reasonable accessible.

PART I - TO GRANT AUTHORIZATION FOR RELEASE OF STUDENT

List the names of persons to whom your child may be released. Include the name and address of parents and three people **other than parents** that may assume responsibility of your child.
Your child will not be released to any person other than those listed on this form.

Parent / Legal Guardian _____ Address _____Phone _____

Work Phone _____

Parent _____ Address _____Phone _____

Work Phone _____

Contact Name _____Address _____ Phone_____

Relationship_____Cell Number_____Work Phone_____

Contact Name _____Address _____ Phone_____

Relationship_____Cell Number_____Work Phone_____

Contact Name _____ Address _____Phone _____

Relationship _____ Cell Number_____Work Phone_____

Contact Name _____ Address _____Phone _____

Relationship _____ Cell Number_____Work Phone_____

Contact Name _____ Address _____Phone _____

Relationship _____ Cell Number_____Work Phone_____

Contact Name _____ Address _____Phone _____

Relationship _____ Cell Number_____Work Phone_____

AUTHORIZATION FOR EMERGENCY CARE

I hereby give consent for the following medical care providers and local hospitals to be called.

Doctor _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

Hospital _____ Address _____ Phone _____

_____
Parent / Legal Guardian Signature