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.

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## 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**