EMERGENCY MEDICAL/HEALTH 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 F____ M ____ Grade_____ Homeroom _____

Residential Parent or Guardian

Mother _____ Day Ph# _____ Cell Ph# _____

Email _____ Pager #_____

Father _____ Day Ph#_____ Cell Ph#_____

Email _____ Pager #_____

Other _____ Day Ph# _____ Cell Ph# _____

Email _____ Pager #_____

Alternate/Other _____ Day Ph#_____ Cell Ph#_____

Email _____ Pager #_____

Name of Relative or 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 _____

____ Respiratory (be specific)_____

_____

____ Bee Sting _____

____ Other _____

____Asthma

____Cancer

____Diabetes

____Hearing Problems ____ Hearing aid(s)

____Heart Problems (be specific)_____

____Concussion head injury – year _____

____Physical Disability (be specific) _____

_____

____Seizures

____Vision problems (be specific) _____

_____

____ Glasses ____Contacts

___ADD/ADHD

___Behavior/emotional problems _____

_____

____Surgeries _____ ___Other (be specific)_____

____Medication, food supplements, modified diets, or fluoride supplements currently being administered to the child (be specific)_____

_____

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.

Date: _____ **Parent/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/Guardian Refusal Signature** _____

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