

## **EMERGENCY MEDICAL/HEALTH AUTHORIZATION**

HEALTH ALERT  $\ \square$ 

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.

Address Change Y N Birth Date Sex F M Grade Homeroom  Residential Parent or Guardian  Mother Day Ph# Cell Ph# Pager # Cell Ph# Ce	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#	Student Name:		Phone#	В	us#
Name of Relative or Childcare Provider   Address   Phone # Relationship   Relationship   Phone # Respective   Phone	Residential Parent or Guardian  Mother			School District		
Name of Relative or Childcare Provider   Address   Phone # Relationship   Relationship   Phone # Respective   Phone	Residential Parent or Guardian  Mother			School Attending		
Mother Day Ph# Cell Ph#	Mother Day Ph# Cell Ph# Enall Pager # Stather Day Ph# Cell Ph# Cell Ph# Enall Pager # Cell Ph# Cell Ph					
Email	Email Day Phil Cell Phil Email Pager #   Cell Phil   Email	Residential Parent or Guardian				
Email	Email Day Ph# Cell Ph# Cell Ph# Cell Ph# Coll Ph# Cell Ph	Mother	Day Ph#		Cell Ph#	
Email	Email Day Ph# Cell Ph		-			
Other Day Ph# Cell Ph#	Other Day Ph# Cell Ph# Email Pager # Alternate/Other Day Ph# Cell	Father	Day Ph#		Cell Ph#	
Email	Email Pager # Alternate/Other Day Ph# Cell Ph# Email Pager # Name of Relative or Childcare Provider Phone Phone # Relationship   I hereby give consent for the following medical care providers and local hospital to be called: Doctor Address Phone	Email			Pager #	
Alternate/Other Day Ph# Cell Ph# Pager #	Alternate/Other	Other	Day Ph#		Cell Ph#	
Email	Email	Email			Pager #	
Name of Relative or Childcare Provider	Name of Relative or Childcare Provider  Address	Alternate/Other	Day Ph#		Cell Ph#	
Address	Address Phone # Relationship Thereby 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 Hospital Phone Below check any current health condition that may require attention during the school day Allergies (be specific)  Foods Physical Disability (be specific)  Respiratory (be specific)  Seizures  Jese Sting Vision problems (be specific)  Seizures  Asthma Glasses Contacts  Cancer ADD/ADHD  Behavior/emotional problems Hearing Problems Hearing aid(s) Heart Problems (be specific)  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 dentists, and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.  Date: Parent/Guardian Signature  PART II – REFUSAL CONSENT Id on 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:	Email			Pager #	
Relationship	Relationship  Doctor	Name of Relative or Childcare Provider				
I hereby give consent for the following medical care providers and local hospital to be called:    Doctor	Intereby give consent for the following medical care providers and local hospital to be called:	Address		Phone # _		
Doctor	Doctor	Themshooding arms of the distance in the second sec				
Dentist	Dentist	I hereby give consent for the following medical (	care providers an	d local hospital to be	called:	
Medical Specialist	Medical Specialist	Doctor	Address	S	Phone	
Hospital Phone  Below check any current health condition that may require attention during the school day	Below check any current health condition that may require attention during the school day Allergies (be specific)	Dentist	Address	3	Phone	
Hospital Phone  Below check any current health condition that may require attention during the school day	Below check any current health condition that may require attention during the school day Allergies (be specific)	Medical Specialist			Phone	
Below check any current health condition that may require attention during the school day	Below check any current health condition that may require attention during the school day  Allergies (be specific)	Hospital			Phone	
Foods	Foods Physical Disability (be specific) Seizures  Bee Sting Vision problems (be specific) Seizures  Other Glasses Contacts  Cancer Glasses Contacts  Hearing Problems Hearing aid(s) Heart Problems (be specific)  Surgeries Other Other Other Surgeries Other (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:	Below check any current health condition that n	nay require attent		day	
Respiratory (be specific)  Bee Sting Other Asthma Cancer Diabetes Hearing Problems Hearing aid(s) Heart Problems (be specific)  Seizures Vision problems (be specific)  Vision problems (be specific)  ADD/ADHD Behavior/emotional problems  Behavior/emotional problems  Other (be specific)	Respiratory (be specific)  Bee Sting Other Asthma Glasses Cancer Diabetes Hearing Problems Hearing aid(s) Heart Problems (be specific)  Surgeries Other (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 Ido 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:					
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Bee Sting		Respiratory (be specific)		Soizuros		
Other		Bee Sting			ms (be specific)	
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Hearing Problems Hearing aid(s) Heart Problems (be specific)  Surgeries Other (be specific)	Hearing Problems Hearing aid(s)	Cancer		ADD/ADHD		
Heart Problems (be specific)  Surgeries  Other (be specific)	Heart Problems (be specific)  Surgeries  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:	Diabetes		Behavior/emo	tional problems _	
SurgeriesOther (be specific)		Hearing Problems Hearing aid(s)				
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