COMFORT ISD STUDENT EMERGENCY CARE AUTHORIZATION

For Office Use Only

Please complete the following information in order for school personnel to provide care for your child if he/she becomes ill or injured while at school. Please update this information if your child's health status changes during the school year. This information unless restricted by law, special health concerns will be shared with appropriate staff to provide the best possible care for your student.

(Please Print)

Year ________ - ________
Grade ______________
Teacher ______________

____
Student's Last Name First Middle ☐ Male ☐ Female

____
Name used if different (Nickname)

Language spoken at home: ☐English ☐Spanish
Father Cell Phone: ______________________
Mother Cell Phone: ______________________

Home Phone: ______________________

______________________________ ______________________________
Home Address (Street, City, State, Zip Code) Mailing Address (Street, City, State, Zip Code)

TRANSPORTATION (Circle one) BUS: Driver's Name: ______________ CAR WALKER BOYS & GIRLS CLUB

Date of Birth: ______________ Insurance Provider: ______________ Medicaid #: ______________

Student Lives with (Circle one) MOTHER FATHER BOTH PARENTS GUARDIAN:__________________________

Mother/Guardian: ______________ Employer: ______________ Work Phone: ______________

Father/Guardian: ______________ Employer: ______________ Work Phone: ______________

Email Addresses: Mother:____ Father:____

Please list all other children in the family under the age of 18:

Name	DOB	Grade/School	Name	DOB	Grade/School

EMERGENCY INFORMATION

In case of an emergency and I cannot be reached, my child may be released to the following person(s):

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

MEDICAL INFORMATION

Please complete the following. Please check all that apply to your student.

Conditions	Past	Present	Name of Medication	Daily	As Needed	At Home	At School
Asthma							
Diabetes							
Epilepsy/Seizure Disorder							
Heart- type of condition:							
Allergies – Type: food insect other: Reaction: ☐ Mild ☐Severe EpiPen: ☐ Yes ☐ No							
Other Conditions/Medications Taken:							
Vision: ☐ Glasses ☐ Contacts ☐ Visual Handicap Hearing Loss: ☐ Left Ear ☐ Right Ear ☐ Hearing Aid ☐ Tubes							
Scoliosis – Date Diagnosed: Treatment: ☐ Bracing ☐ Surgery ☐ Other:							
Physical Limitations:							
Other information/legal restrictions that would be significant in the care of your child?							

List any Other Problems: ____

List Allergies & Reaction: ____

Preferred Doctor: ______________________ Phone: ______________

Preferred Hospital: ______________________ Phone: ______________

Preferred Dentist: ______________________ Phone: ______________

Comfort ISD does not provide medications. Medications must be in the original bottle with a request signed by the physical and parent.

☐ *I have read and understand the CISD Health Services Policies. I hereby Authorize Comfort ISD personnel to seek emergency medical services for my child, as they deem necessary. I will NOT hold Comfort ISD, its Board of Trustees, or its employees medically or financially responsible for the treatment of my child.*

Falsification of any information on this card is punishable by fine. (Texas Education Code 21.031)

______________________ ______________________________
DATE SIGNATURE OF PARENT OR GUARDIAN

RETURN TO THE SCHOOL NURSE