St. Joseph Consolidated School

2018 - 2019 EMERGENCY MEDICAL AUTHORIZATION FORM

PLEASE PRINT ALL INFORMATION

PURPOSE:

* To enable parents / guardians to authorize the provision of emergency treatment for their student who become ill or injured while under school authority and / or when parents / guardians cannot be reached.
* To obtain a Health History, Medication History of the student and to assist the School Nurse with preparing for Field Trips.

STUDENT NAME: ____GD:______ DATE OF BIRTH: ___________MALE / FEMALE

ADDRESS____ PHONE ___________________

Parent or Guardian

Mother's Name____Daytime # _________________Cell # _____________________

Father's Name____Daytime # __________________Cell # ____________________

Other name /Relationship ____________________________________ Daytime # _______________ Cell # __________________

Name of Relative/Childcare Provider______________________________Relationship_______________Cell # __________________

Additional adults who have permission to pick up your child:

1). Name ______________________________ Relationship : _____________________ Phone # s __________________

2). Name ______________________________ Relationship : _____________________ Phone # s __________________

PART 1 OR 2 MUST BE COMPLETED

PART 1 : TO GRANT CONSENT for Medical Care

❖ I hereby give consent for the following medical care providers/local hospital to be called:

DOCTOR:____ Phone__________________

DENTIST:____ Phone__________________

MEDICAL SPECIALIST:____________________________________ Phone__________________

LOCAL HOSPITAL:_______________________________________ Phone__________________

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 above-named doctor or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent / Guardian ____ Date _______________

Medical Insurance Provider : _______________________ Member Name :_______________________ Member ID # : _______________

(print)
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PART 2 : REFUSAL TO CONSENT for Medical Care

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take the following action:____

Signature of Parent / Guardian ____ Date _______________

--- OVER ---

Student Name: ____ Grade: _______

✓ Please check the following health concerns or medial conditions your child has or has had in the past.

________ Abnormal Spinal curve*
* Is under medical care ___________
________ Allergies** (Food, Meds, Other)
** See Box below
_______ ADD / ADHD
_______ Anemia
_______ Anxiety
_______ Arthritis
_______ Asthma
Inhaler: ______________________
Nebulizer: ___________________
_______ Behavioral Concerns
_______ Birth Congenital malformation
_______ Bladder / Bowel Issues
_______ Cancer, Type ___________
_______ Concussions
_______ Cystic Fibrosis
_______ Depression
_______ Diabetes
_______ Eating Disorder
________ Eczema
_______ Emotional Disorder
_______ Glasses / Contacts
_______ Headaches
_______ Heart Condition
_______ Hearing Problems / Hearing Aides
_______ Hemophilia
_______ High Blood Pressure
_______ High Cholesterol
_______ Illness Leading to Hospitalization
_______ Injury Leading to Hospitalization
_______ Kidney Disease
_______ Migraines
_______ Nervous Twitches / Tics
_______ Seizures
_______ Sickle Cell Disease
_______ Substance Abuse (alcohol/drugs)
_______ Suicide Attempt
_______ Toothache / Dental Problems
_______ Vision Disorder / Problem
_______ OTHER _________________
____

Explain checked items: ____
____
____

Please add **comments / concerns** you have about your child's health, development, behavior, family or home life that you would like the School Nurse or Emergency Personnel to be aware of.
____
____

** **Allergies:** Please list and describe allergies and reactions:
____
____

Medication Information: Please list medications, supplements and vitamins your child takes daily, as needed or frequently.

Name of Medication	What it is taken for ?	How often (Daily /as needed) ?	What time (s) med is taken ?

If your child **requires medication during the school day** (prescription or over the counter), a **Medication Permit**, signed by a doctor is required for each medication. The Permits are available on the school web site under "Parents"/ "Health Services".

❖ **If your child takes medications and goes on an overnight field trip, each medication will need a Medication Permit.** ❖

This information may be shared with school personnel on a "need to know" basis in order to provide for your child's safety and educational success. In addition, a copy of this form will be sent with staff on every field trip your child participates in.

Form completed by : ______________________________________ Date: ________________