



STUDENT EMERGENCY MEDICAL AUTHORIZATION FORM 2019-2020

Student's Legal Name: _____ Grade: _____

Student Home Address: _____ Zip: _____

Home Phone: _____ Date of Birth: _____ Age as of Aug. 31, 2019: _____

<u>Father's Information:</u>	<u>Mother's Information:</u>
Name: _____	Name: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Business Phone: _____	Business Phone: _____
Cell Phone: _____	Cell Phone: _____
Daytime Phone: _____	Daytime Phone: _____

Please take a moment to carefully answer the questions below about your child. This information will help us care for your child during the school day.

1. Does your child have any **chronic health conditions**? (Check which ones)
- | | |
|---|--|
| <input type="checkbox"/> Asthma or other respiratory problems | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Skin problems |

Any other conditions? _____

Has your child been seen in the **emergency room** or hospital for this condition? Yes No

If yes, please comment in detail: _____

2. Does your child have any **allergies** to:
- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Food |
| <input type="checkbox"/> Bee Stings | <input type="checkbox"/> Other _____ |

Please explain the type of reaction: _____

Does your child require an **Epi-pen**? Yes No **Benadryl**? Yes No

3. Has your child had any **serious illness, operation, hospitalization, or injuries**? Yes No

If yes, please explain: _____

4. Is your child on any **medication**? Yes No **Inhalers**? Yes No

If yes, list medication and directions: _____

Does the medication need to be given at school? Yes No

Note: Medication can only be given at school with signed permission by the doctor and parents.
Forms are available in the school office or on line. (Continued)

5. Does your child have any limitations or disabilities? Yes No

If yes, please explain: _____

6. Has your child had any problem with **vision?** Yes No

Do they wear eyeglasses? Yes No

Has your child had any problem with **hearing?** Yes No

Have they had ear ventilation tubes? Yes No

If yes to either, please explain: _____

PARENTS: If your child has a life-threatening illness, it is the parent/guardian's responsibility to notify the school prior to school attendance.

NOTE: For the safety of your child, this information will only be shared with those who have a need to know.

EMERGENCY AUTHORIZATION: (In an emergency we will always call 911 first.)

I authorize you to call Dr. _____ Phone: _____

My choice of hospital is: 1) _____

2) _____

(Parents are responsible for any and all medical services, including ambulance.)

I give authorization for either a family member or friend to pick up my child in the event I cannot be reached, (to include illness, appointments, and emergency evacuations). **Please make sure all numbers are current and updated throughout the school year.** It is imperative that someone be available at all times during the school day in case of emergency. Please list in order of preference:

1) Name:	3) Name:
Relationship:	Relationship:
Day Phone:	Day Phone:
Cell Phone:	Cell Phone:
2) Name:	4) Name:
Relationship:	Relationship:
Day Phone:	Day Phone:
Cell Phone:	Cell Phone:
<i>OUT OF AREA CONTACT PERSONS</i>	
1) Name:	2) Name:
Relationship:	Relationship:
Day Phone:	Day Phone:
Cell Phone:	Cell Phone:

Parent/Custodial or Legal Guardian Signature:

_____ Date _____