MEDICAL AUTHORIZATION

STUDENT INFROMATION

Name____ Gender____ Age_____ Grade Entering_________ Birthday_____________________

Student email____ Student cell # _____________________________________

Address____ Hm Phone________________________

Father Name____ Wk # _________________________ Cell # _____________________________

Mother Name____ Wk # _________________________ Cell # _____________________________

Family E-mail Address____

MEDICAL INFORMATION

Daily Medications____ Allergies____

Health Conditions____ Treatment ____

Medical Insurance Company ____Policy No._______________________

Name of Doctor to be Called ____Phone No. _______________________

Name of Dentist to be Called ____Phone No. ______________________

Name of Hospital Preferred ____

LIST TWO PERSONS TO CONTACT IF PARENTS CANNOT BE REACHED:

Name____________________________________Relationship________________ Contact number(s)_____________________________________

Name____________________________________Relationship________________ Contact number(s)_____________________________________

I hereby give my consent for this child to participate in the School Health Services Program. This means my child may receive emergency care in school and at school sponsored events (including school transportation to and from the event) if needed, and health appraisals at school, including screenings such as vision, hearing, and growth and development.

In case of an accident or illness, on campus or at a school sponsored event, **where treatment is not needed**, but where my child is unable to remain at school. I request the school to contact me. If I am unable to be reached I request that one of the person listed above be contacted to care for my child until I can be reached.

In the event of a **serious accident, loss of limb, or illness**, on campus or at a school sponsored event, I request the school to contact me at the phone numbers listed. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated and to follow his/her instructions. If it is not feasible to contact me, the physician, or the dentist, the school may make whatever arrangements are necessary to provide emergency care and treatment for my child. I agree to be financially responsible for the child's care and treatment.

In the event of a **life threatening accident or illness**, on campus or at a school sponsored event, I understand that the school may contact the 911 emergency medical systems immediately. I agree to be financially responsible for the child's care and treatment.

Parent Signature____ Date_______________________________________

IN THE EVENT OF AN EMERGENCY WE WILL ACCESS THE 911 EMERGENCY SYSTEM. IF YOU WOULD LIKE TO GIVE THEM ADVANCE PERMISSION TO BEGIN TRANSPORT AND TREATMENT OF YOUR CHILD, PLEASE SIGN THE FOLLOWING STATEMENTS

PERMISSION TO TRANSPORT STATEMENT

I do hereby state that I am the parent or legal guardian of the child named on this form. In order to expedite care of this child, I hereby give my permission for the responding emergency team to immediately initiate treatment and transport of this child to the preferred or appropriate medical facility, according to what they deem is indicated by the nature or extent of the injuries. I agree to be financially responsible for this child's treatment and transport. I will notify the school of any changes of this information.

PERMISSION TO TREAT STATEMENT

I do hereby state that I am the parent or legal guardian of the child named on this form. In order to expedite care of this child, I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I agree to be financially responsible for this child's treatment. I also request that I be notified of my child's condition and admission at soon as possible. If I am unable to be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission.

Parent Signature____ Date______________________________________