

MEDICAL AUTHORIZATION

STUDENT INFORMATION

Name _____ Gender _____ Age _____ Birthday _____ SSN _____
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 will 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 screening 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 authorized the school to contact the physician or dentist indicated and to follow his instructions. If it is impossible to contact the physician or dentist, the school may make whatever arrangements are necessary to provide emergency care and treatment for my child.

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 of 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 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 _____