EMERGENCY MEDICAL AUTHORIZATION & HEALTH HISTORY

Student Name: _____ Grade: _____ Date of Birth: _____ School Year: _____

EMERGENCY MEDICAL AUTHORIZATION

Complete the appropriate section to either grant consent or refuse to consent for emergency medical treatment. The purpose is to enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

_____ CONSENT FOR TREATMENT - *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 the practitioners listed below, or, in the event designated practitioner is not available, by another licensed practitioner; and 2) the transfer of the child to any hospital reasonably accessible. This authorization is valid for the current school year or until such time as I withdraw the authorization in writing.*

Doctor _____ Phone _____

Hospital _____ Phone _____

Dentist _____ Phone _____

Parent Signature _____ Date _____

_____ REFUSAL TO CONSENT FOR TREATMENT - *I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:*
****Staff members are NOT to abide by "Do Not Resuscitate" agreements unless ordered to do so by a court of law****

_____

Parent Signature _____ Date _____

HEALTH INFORMATION & MEDICAL HISTORY

I have been told by a Physician or Health Care Provider that my child has the following condition(s). Select all that apply and list any additional information in the space provided.

Respiratory/Breathing
___Asthma ___Activity-Induced Asthma
___Inhaler required at school
___Lung Disease
___Tuberculosis - Latent or Active

Heart/Circulatory
___Blood/Clotting ___Hemophilia
___Van Willebrand ___Murmur (recent)
___Heart Disease/Problem _____

Stomach/Intestinal
___Crohn's Disease ___Acid Reflux
___Stomach/Bowel Disease _____
___Bladder/Kidney concerns _____
___Food Intolerance _____

Neurological
___Migraines ___Frequent Headaches
___Seizures ___Epilepsy
___Shunt
___Head Injury/Concussion

Allergies
___Insect/Bees ___Latex
___Animals ___Food
___Medication ___Environmental

Diabetes/Endocrine
___Type 1 Diabetes
___Type 2 Diabetes
___Other _____

Muscular/Skeletal
___Muscle Condition _____
___Bone Condition _____
___Joint Condition _____
___Skin Condition _____

Developmental/Psychological/Behavioral
___Autism ___Asperger's
___ADD/ADHD ___Anxiety
___Depression ___OCD
___Other

Please provide details for the items you have selected in the above section: _____

_____

_____

MEDICATIONS

EMERGENCY MEDICATIONS

My child is prescribed the following emergency medication(s) that may be needed during school hours: ___Diastat ___EpiPen ___Glucagon ___Inhaler/Nebulizer

DAILY MEDICATIONS

Please list any medication your child takes regularly including prescriptions, over-the-counter, vitamins, and herbal supplements. If your child will need to take a prescription medication during school hours, you **MUST** complete a **Prescription Medication Permission Form** and have it filed in the school health office.

Medication	Dosage	AM/Noon/PM	Reason Taken	Taken at School
				Yes No
				Yes No
				Yes No

OVER-THE-COUNTER MEDICATION PERMISSION

I hereby authorize the nursing or trained school personnel to act on my behalf in administering the following **selected** medications, as directed on the product package, on an as needed basis to help with minor discomforts during school hours. ****Please indicate if your child requires medication that is dye-free****

___Acetaminophen (Tylenol) ___Ibuprofen (Advil) ___Antacid (Tums) ___Benadryl ___Pepto ___Menstrual Relief (Midol) ___Cough Drops _____Imodium

Any medication brought to school must be in the original labeled container and kept in the school health office.
All medications will be dispensed as directed on the package **or** doctor's prescription.

To ensure the care and safety of my child, I agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis and in a confidential manner. I agree to alert the school nurse and my child's teacher of any change in medications and/or health status of my child. I will furnish the school with a **current** phone number, address, and valid emergency contacts.

Parent/Guardian Signature _____ Date _____