EMERGENCY MEDICAL AUTHORIZATION
2020-2021

Student Legal Name (Last-First-Middle) _____ Birthdate _____

Address _____ City _____ Zip _____ School District _____

Grade _____ Home Room Teacher _____

Primary Contact	Mother/Guardian	Father/Guardian
Place of Employment	_____	_____
Cell #	_____	_____
Home #	_____	_____
Work #	_____	_____

Authorized persons to assume responsibility for school dismissal and provisions of care when a parent/guardian cannot be reached:

1._____ Phone_____ Relationship_____

2._____ Phone_____ Relationship_____

Insurance: □ Private – Name _____ □ Medicaid/Medicare – Name _____ □ None

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor _____ Phone _____
Dentist _____ Phone _____
Hospital/Emergency Room _____

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 doctors, or, in the event the designated practitioner is not available, by another licesnsed 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

PART II: REFUSAL TO CONSENT

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 action:

_____

_____

_____

_____

_____

_____

_____ _____
Signature of Parent/Guardian Date

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IMPORTANT NOTE:

STUDENTS WILL NOT BE ALLOWED TO ATTEND CLASS UNTIL ALL FORMS ARE COMPLETED, SIGNED, AND RETURNED TO THE SCHOOL OFFICE. ADDITIONALLY, IMMUNIZATION RECORDS MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.

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COMPLETE BOTH SIDES

Health History (Parent Fills Out)

Student's Name	Sex	Date of birth
	□ Male □ Female	/ /

Student Health Conditions

□ **YES**, my child receives regular medical/health care for the following conditions:		□ **NO** medical conditions
□ Allergies	□ Diabetes	□ Seizure disorder
□ Asthma	□ Depression	□ Sickle cell anemia
□ ADD/ADHD	□ Ear problem/hearing difficulty	□ Skin conditions
□ Autism	□ Emotional concerns	□ Speech problems
□ Behavior concerns	□ Headaches	□ Traumatic brain injury
□ Birth/congenital malformations	□ Heart problems	□ Vision problems (glasses, contacts)
□ Bone/muscle/joint problems	□ Hemophilia	□ Other _____
□ Blood problems	□ Juvenile arthritis	□ Other _____
□ Bowel/bladder problems	□ Lead poisoning	□ Other _____
□ Cancer	□ Migraines	□ Other _____
□ Cystic fibrosis	□ Neuromuscular disorder	□ Other _____

DOES YOUR CHILD HAVE ANY LIFE THREATENING ALLERGIES? □ **YES** □ **NO**

(If yes, please list and describe symptoms.) _____

DOES YOUR CHILD USE AN EPI-PEN? □ **YES** □ **NO**

Please list any prescription medication that your child takes on a regular basis. **Medication and dose**	**Time**	**Reason**

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MEDICATION ADMINISTRATION

MEDICATION WILL NOT BE ADMINISTERED AT SCHOOL UNLESS **FORM A** AND **FORM B** HAVE BEEN SIGNED AND DATED BY THE PROVIDER AND PARENT.

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I release and agree to hold the East Dayton Christian School Board, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ **Date:** _____