

**Public Schools HEALTH AUTHORIZATION FORM**

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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**NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:**

**SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION**

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian cannot be reached. **PLEASE KEEP THESE NUMBERS CURRENT!**

Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian		Phone #3
Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian		Phone #3

	Emergency Contact List	Relationship	Phone #1	Phone#2	Phone #3
1.					
2.					
3.					
4.					

**Siblings in Other Schools**

	Name	School/Daycare	Grade	DOB
1.				
2.				
3.				

**SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box**

My child has no health conditions including those listed below

<input type="checkbox"/> Allergies: <input type="checkbox"/> Seasonal <input type="checkbox"/> Food (List): _____ <input type="checkbox"/> Other Allergy (List): _____ <input type="checkbox"/> Has EpiPen prescription
<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Congenital/Genetic <input type="checkbox"/> Ear/Nose/Throat <input type="checkbox"/> Pulmonary (Other than Asthma)
<input type="checkbox"/> Asthma Needs Inhaler at School: <b>Y N</b> <input type="checkbox"/> Eye/Vision Wears glasses/contacts: <b>Y N</b> <input type="checkbox"/> Diabetes (circle one) Type 1 Type 2 <input type="checkbox"/> Cardiovascular (List) _____ High Blood Pressure: <b>Y N</b>
<input type="checkbox"/> Cancer <input type="checkbox"/> Dermatologic/Skin <input type="checkbox"/> Stomach/GI <input type="checkbox"/> Musculoskeletal
Long Term Medications (List): <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Bladder/GU <input type="checkbox"/> Dental/Oral
<input type="checkbox"/> Any Other Health Conditions: _____ <input type="checkbox"/> Endocrine Other than Diabetes <input type="checkbox"/> Hematology/Bleeding Disorders <input type="checkbox"/> Psychiatric (List Meds): _____ <input type="checkbox"/> Migraines

**SECTION THREE - INSURANCE INFORMATION**

Student's Insurance:	Subscribers Name:	ID#
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**TO GRANT CONSENT**

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name:

First Name:

