

Emergency Medical Authorization

Student's Name _____ DOB _____

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____

Home # _____

Work # _____

Cell # _____

Father's Name _____

Home # _____

Work # _____

Cell # _____

Other's Name _____

Home # _____

Relationship _____

Work # _____

Cell # _____

PART I OR 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 _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named Doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) 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 OR GUARDIAN REQUIRED TO GRANT CONSENT

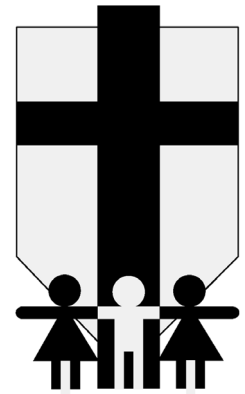
Signature _____ Date _____

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 medical treatment, I wish the school authorities to take the following action:

SIGNATURE OF PARENT OR GUARDIAN REQUIRED for REFUSAL TO CONSENT

Signature _____ Date _____



**Lebanon
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Please complete reverse side...

Student Health History

Student Name: _____

I. Health Conditions. Please check any that this child has had*: **NONE**

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Spinal curvature
(<i>scoliosis, etc</i>) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eczema | <input type="checkbox"/> Near-drowning or near suffocation |
| <input type="checkbox"/> Allergies or hayfever | <input type="checkbox"/> Emotional | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Rubella (3 day measles) |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Frequent skin infections | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Positive TB test |
| <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Measles (" <i>old fashioned</i> " or " <i>10 day</i> ") | <input type="checkbox"/> Toothaches or dental infections |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Meningitis or encephalitis | <input type="checkbox"/> Urinary tract infection |
| | <input type="checkbox"/> Other | <input type="checkbox"/> Wetting during day |

*Please explain any checked item _____

II. Injuries and Illnesses. Please list any severe injuries or illnesses: **NONE**

Injuries / Illnesses	Age of Child	Hospitalized (yes or no)
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. Allergies. Please list and describe allergies or reactions: **NONE**

Medicines/Drugs* _____

Foods/Plants/Animals/Other _____

Recommended treatment if allergy is severe _____

List any emergency medication your child requires (epi-pen, inhaler, etc.) _____

* Please complete and have your doctor sign Medication Administration Form, available online or at school office.

IV. Additional Information

What medications are given daily? _____ **NONE**

What medications are given frequently, but not daily? _____

This child is usually: _____ very active _____ normally active _____ rather inactive

Is child under medical treatment at present? Yes or No (*Circle one*)

If yes: Reason _____

Physician _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

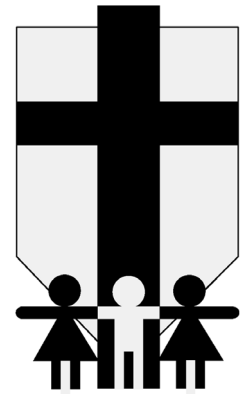
V. To my knowledge, above information is current and accurate.

Parent signature _____ Date _____

VI. ATTACH CURRENT IMMUNIZATION OR EXEMPTION FORM, SIGNED BY DOCTOR.

State law requires that immunization forms for each student be on file at school within 30 days of the first day of school, or school attendance will not be permitted.

VII. PRESCHOOL AND PREKINDERGARTEN STUDENTS - COMPLETE AND ATTACH PHYSICAL EXAM FORM (attached). *State law requires that preschool and prekindergarten students have a physical exam within six months prior to the first day of school, and that the attached form be on school file within 30 days of the first day of school, or school attendance will not be permitted.*



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