STUDENT EMERGENCY MEDICAL FORM

(Please print)

STUDENT'S NAME:	**SCHOOL YEAR**	**DATE OF BIRTH**	**PRESENT GRADE**

STUDENT'S ADDRESS:	**PHONE #**

Purpose: To authorize the emergency treatment for the child who becomes ill/injured while under school care and authorize release of child to name(s) listed below when Parent/Guardian cannot be reached.

PART I (Complete this Section only if you wish to grant consent)

RESIDENTIAL PARENT OR GUARDIAN:

MOTHER'S NAME & ADDRESS:	MOTHER'S DAYTIME PHONE:
MOTHER'S EMAIL ADDRESS:	MOTHER'S CELL PHONE:
FATHER'S NAME & ADDRESS:	FATHER'S DAYTIME PHONE:
FATHER'S EMAIL ADDRESS:	FATHER'S CELL PHONE:
EMERGENCY CONTACT / RELATIONSHIP TO CHILD:	EMERGENCY CONTACT PHONE:
EMERGENCY CONTACT / RELATIONSHIP TO CHILD:	EMERGENCY CONTACT PHONE:

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:

DOCTOR'S NAME:	PHONE#:
DENTIST'S NAME:	PHONE#
MEDICAL SPECIALIST:	PHONE#:
LOCAL HOSPITAL:	ER PHONE#:

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 doctor, or in the event the designated preferred practitioner is not available, by another licensed 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.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

DATE:	**SIGNATURE OF PARENT/GUARDIAN:**

PART II (Complete this section only if you wish to refuse consent)

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 room treatment, I wish school/district authorities to take the following action:

DATE:	**SIGNATURE OF PARENT/GUARDIAN:**

(PLEASE TURN OVER & COMPLETE)

STUDENT HEALTH HISTORY
(To be completed by Parent/Guardian)

STUDENT'S NAME: _____

Check One:

Holmes ☐ Grade:	Amity ☐ Grade:	Jr./Sr. High ☐ Grade:

HEALTH CONDITIONS – Please check any that apply to your child

- ☐ Abdominal/Spinal curvature (scoliosis)
- ☐ ADHD/ADD
- ☐ Allergies – Food***
- ☐ Allergies – Medications
- ☐ Allergies – Other**
- ☐ Anemia
- ☐ Asthma**
- ☐ Behavioral problems
- ☐ Birth or congenital malformations
- ☐ Cancer – Type: _____
- ☐ Chicken Pox
- ☐ Cystic Fibrosis
- ☐ Dental problems
- ☐ Diabetes
- ☐ Diarrhea/constipation
- ☐ Eating problems
- ☐ Ear infections
- ☐ Eczema
- ☐ Headaches/migraines
- ☐ Hearing Aids
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Meningitis/encephalitis
- ☐ Menstrual cycle problems
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures/Epilepsy
- ☐ Skin rashes (frequent)
- ☐ Stool soiling
- ☐ Substance abuse (alcohol/drugs)
- ☐ Suicide attempt
- ☐ Throat infection (frequent)
- ☐ Tics/nervous twitches
- ☐ Urinary Tract Infections
- ☐ Wetting (day or night)
- ☐ Other _____

Please comment on the above: _____

_____

***Student with food allergies must complete the **FOOD ALLERGY ACTION PLAN** form.

** Student with allergies/asthma: Is inhaler needed at school: ☐ YES ☐ NO

Epi Pen needed at school: ☐ YES ☐ NO

HEARING AND VISION

Hearing problems: ☐ YES ☐ NO When: _____ Ear Tubes: _____

Wear glasses/contacts: ☐ YES ☐ NO Reason: _____ Date of last eye exam: _____

INJURIES AND ILLNESSES – Please list any severe injuries or illnesses:

Injury/Illness: _____

Age: _____ Hospitalization: _____

Comments: _____

ADDITIONAL INFORMATION

What medications are given daily/frequently: _____

Student is usually: ☐ Very active ☐ Normally active ☐ Inactive

Do you have any concerns about how your child gets along with others: _____

Do you have other comments/concerns about this student's health, development, behavior, family, home life that you would like to share with the school: _____

_____

PAST OR PRESENT SERVICES RECEIVED

Previous Psychological evaluation: _____ (YEAR) Counseling/Mental Health Services: _____ (YEAR)

Special Education Support: _____ (YEAR) Speech Therapy: _____ (YEAR)

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I GIVE PERMISSION AND hereby authorize the school nurse and/or school health service specialist to share necessary health information about my child with the appropriate school staff. This information will be shared in a confidential manner. This authorization is valid for the current calendar school year only. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become education records protected by the FERPA.

_____ **Date:** _____

(Print Name) (Signature)

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I DO NOT GIVE PERMISSION TO SHARE INFORMATION:

_____ **Date:** _____

(Print Name) (Signature)

Revised 2/15 (orange)