St. Francis de Sales SCHOOL

☐ NEW ADDRESS / PHONE NUMBER HEALTH ALERT ☐

EMERGENCY MEDICAL AUTHORIZATION

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. This information may be shared with the educational team to best meet your child's needs.

Student Name _____ Phone # _____ Bus # _____

Address _____ School District _____

_____ School Attending _____

Address Change Y☐N☐ Birth Date _____ Sex M☐F☐ Grade _____ Home Room _____

Residential Parent or Guardian

Mother_____ Day Ph # _____ Cell # _____

Email _____ Pager # _____

Father _____ Day Ph # _____ Cell # _____

Email _____ Pager # _____

Other Name _____ Day Ph # _____ Cell # _____

Name of Relative or Childcare Provider _____

Address _____ Phone # _____

_____ Relationship _____

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

Doctor _____ Phone # _____

Dentist _____ Phone # _____

Medical Specialist _____ Phone # _____

Hospital _____ Phone # _____

Below check any *CURRENT* health condition that may require attention during the school day:

☐ Allergies (be specific)
- ☐ Foods _____ EpiPen ☐Yes ☐No
- ☐ Medicines _____
- ☐ Bee Stings EpiPen ☐Yes ☐No
- ☐ Other _____

☐ Asthma Uses emergency inhaler ☐Yes ☐No

☐ Cancer

☐ Diabetes

☐ Seizures

☐ Heart problems (be specific) _____

_____

☐ Physical disability (be specific) _____

_____

☐ Other health conditions (be specific) _____

_____

☐ Previous surgeries (be specific)_____

_____

☐ Previous concussion/head injury-year _____

☐ Hearing problems Has hearing aids ☐Yes ☐No

☐ Vision problems (be specific) _____

_____

Wears: ☐ Glasses ☐ Contacts

☐ ADD/ADHD

☐ Behavior/emotional problems _____

_____

☐ No current health conditions

List all medications and dosages your child receives on a continual basis: _____

_____

PLEASE COMPLETE PART I *OR* PART II — NOT BOTH

Part I — TO GRANT CONSENT

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 designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date _____ Parent or Guardian Signature _____

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 no action or to: _____

_____

_____

Date _____ Parent or Guardian **REFUSAL** Signature _____