

**EMERGENCY MEDICAL AUTHORIZATION**

**2022-2023**

Student Legal Name (Last-First-Middle) \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ School District \_\_\_\_\_

Grade \_\_\_\_\_ Home Room Teacher \_\_\_\_\_ Email address \_\_\_\_\_

Primary Contact Name _____	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 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.

\_\_\_\_\_  
 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

\*\*\*\*\*

**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.**

\*\*\*\*\*

**COMPLETE BOTH SIDES**

## Health History (Parent Fills Out)

Student's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /      /
----------------	--	---------------------------

### Student Health Conditions

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

\*\*\*\*\*

### 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.**

\*\*\*\*\*

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:** \_\_\_\_\_