Dexter Consolidated Schools

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

Student's Full Legal Name _____ **Grade** _____

Student's **Mailing** Address _____

Student's **Physical** Address _____

Student's Home Phone Number _____Student's Birth Date_____ Age____

Mother's Full Name_____ Work/cell number_____

Father's Full Name_____ Work/cell number_____

Guardian_____Work/cell number_____

Student lives with_____

Email address of parent/guardian _____

ALTERNATE EMERGENCY CONTACTS (Local people to contact if parent can't be reached)

1. Name _____ Relation _____ Phone _____

2. Name_____ Relation _____Phone_____

3. Name_____ Relation_____Phone _____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber's Name_____

ID or Group Number_____

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary.

Doctor_____ **Phone number**_____

Dentist_____ **Phone number**_____

Hospital _____ **Phone number**_____

If for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child 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.

SIGNATURE OF PARENT/GUARDIAN_____**DATE**_____

FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY TO WHICH THE **SCHOOL NURSE** ***SHOULD BE ALERTED***

Student Name_____Grade_____

Please indicate if student has had or is currently receiving medication for any of the following conditions: Give year or age when problem occurred.

CONDITION	***DATE/DATES OF OCCURENCE***
___Vision problems, glasses/contacts	_____
___Asthma	_____
___Uses inhaler	_____
___Diabetes	_____
___Ear/Hearing problems	_____
___Emotional problems	_____
___Seizures	_____
___Heart Problems	_____
___Hepatitis	_____
___Meningitis	_____
___Migraines	_____
___Muscular weakness	_____
___Bleeding disorders	_____
___High blood pressure	_____
___Infectious disease	_____
___Last tetanus shot	_____
___Seasonal allergies	_____
___Environmental allergies	_____
___Allergic reactions	_____
___Disability	_____

___Hospitalized for serious illness, surgery or accident_____