



# 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.

<b><u>CONDITION</u></b>	<b><u>DATE/DATES OF OCCURENCE</u></b>
___ 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	_____