MIAMI EAST LOCAL SCHOOLS **SCHOOL YEAR 2014-2015**

Emergency Medical Authorization Form

STUDENT NAME: _____ **HOME PHONE :** _____
ADDRESS: _____ **BIRTH DATE:** _____
CITY: _____ **GRADE:** _____

PARENTS OR GUARDIANS

Mother's Name _____ E-Mail: _____
Address: _____ Home Phone:_____
City: _____ Cell Phone: _____
Place of Employment _____ Work Phone: _____

Father's Name _____ E-Mail: _____
Address: _____ Home Phone:_____
City: _____ Cell Phone: _____
Place of Employment _____ Work Phone: _____

CUSTODIAL PARENT: (If applies, circle one) MOTHER FATHER JOINT

OTHER PARENTS OR GUARDIANS WITH AUTHORIZATION TO CONSENT FOR CARE

Stepmother's Name _____ E-Mail: _____
Address: _____ Home Phone:_____
City: _____ Cell Phone: _____
Place of Employment _____ Work Phone: _____

Stepfather's Name _____ E-Mail: _____
Address: _____ Home Phone:_____
City: _____ Cell Phone: _____
Place of Employment _____ Work Phone: _____

You must complete either PART I or PART II below. *Purpose*: to enable parents and/or 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 side will be used during school hours and for authorized school activities including field trips.

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 following health care providers, or if the designated preferred practitioner is not available, by another licensed healthcare provider or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Primary Care Physician: _____ Telephone: _____
Dentist: _____ Telephone: _____
Medical Specialist: _____ Telephone: _____
Local Hospital:_____ Telephone:_____

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. The following are facts concerning the child's medical history, including allergies, medications being taken and any physical impairments or chronic conditions to which a physician should be alerted include:

_____
_____
Signature or 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 or Guardian_____Date_____

(CONTINUE ON OTHER SIDE)

STUDENT NAME: _____

TELEPHONE CALLING ORDER

During the course of the school year there are times when a student may need to leave school due to illness or communicable disease requiring transportation home. Parents or guardians may not be available during these times. Students who are ill must be dismissed to a responsible adult. Please list below the names of five adults (including yourself as parent/guardian) who you would prefer for us to call in case of an illness or emergency. ***Please put these names in the order of who should be called <u>first, second, etc</u>***. Please notify the school when telephone numbers change.

	Name	Relationship to Student	Phone: Home, Work, Cell
1.	_____	_____	_(_____)_____
2.	_____	_____	_(_____)_____
3.	_____	_____	_(_____)_____
4.	_____	_____	_(_____)_____
5.	_____	_____	_(_____)_____

In order to help us plan for a safe and healthy school experience for your child, please check and give details of the any of the following that currently apply to this student:

___Asthma_____
___Bleeding Disorder_____
___Depression_____
___Diabetes_____
___Cancer_____
___Eating Disorder, anorexia, bulimia, obesity_____
___Epilepsy_____
___Has a cast, brace, wheelchair or other supportive or assistive device_____
___Heart Condition_____
___Life threatening allergies (anaphylaxis) _____
___Food or other allergies (non life threatening) _____
___Medication during the school day_____
___Mental health concerns_____
___Pregnancy_____
___Shunt_____
___Smoking_____
___Wears a hearing aid or is deaf_____
___Wears corrective lenses (glasses or contacts)_____
___Wears prosthesis_____
___My child has special health care needs. Please have the school nurse contact me to develop a school based health plan.

The space below is provided for you to list any <u>additional</u> information concerning your child's health or medical conditions of which the school staff should be aware_____
_____
_____

Yes ☐ No ☐ I give permission to share this health information with school staff as needed.

Parent/Guardian Signature:_____ Date_____

Revised August, 2010