

Buckeye Valley Local Schools

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 persons responsible with the care of my child.

Student's Name: _____ Birthdate: _____ Grade: _____

Home Address: _____ Home Phone Number: _____

City/State/Zip: _____ Date of Last Tetanus: _____

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other: _____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

____ **MOTHER** - Name _____ Email address _____

Address (city, state, zip) _____

Home# _____ Cell# _____ Work# _____

____ **FATHER** - Name _____ Email address _____

Address (city, state, zip) _____

Home# _____ Cell# _____ Work# _____

____ **OTHER** - Name _____ Relationship _____

Address (city, state, zip) _____

Home# _____ Cell# _____ Work# _____

____ **OTHER** - Name _____ Relationship _____

Address (city, state, zip) _____

Home# _____ Cell# _____ Work# _____

COMPLETE **ONLY ONE** OF THE FOLLOWING: I. Consent for Treatment **OR** II. Refusal to Consent

I. CONSENT FOR TREATMENT

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

Preferred Physician: _____

Office # _____

Preferred Dentist: _____

Office # _____

Medical Specialist: _____

Office # _____

Preferred Hospital: _____

ER # _____

II. REFUSAL TO CONSENT

I do NOT give 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:

Parent/Guardian

Signature: _____

Address: _____

Date: _____

AND

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 preferred doctor indicated, or, in the event the designated preferred 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.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken and any physical impairment of which a physician and/or school should be alerted: _____

Parent/Guardian Signature: _____ Date: _____

(PLEASE COMPLETE BOTH SIDES)

Student Name _____

Medical History- Please check any that child has had:

- | | |
|---|--|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis, etc.) | <input type="checkbox"/> Frequent sore throat infections |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Heart Disease, type _____ |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Joint problems or arthritis |
| <input type="checkbox"/> Bedwetting: at night _____ during day _____ | <input type="checkbox"/> Kidney disease, type _____ |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Near drowning/suffocation |
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Painful menstrual cramps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Concern for relations with siblings or friends | <input type="checkbox"/> Self hurt behaviors |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stool Soiling (encoporesis) |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Substance abuse (alcohol/drugs) |
| <input type="checkbox"/> Emotional/depression/anxiety disorder | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Ear problems, poor hearing | <input type="checkbox"/> Toothache or dental infections |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frequent skin infections | |

During the past 3 years:

Any hospitalizations: Yes/No Explain: _____

Any illness lasting more than a week: Yes/No Explain: _____

Any injuries requiring medical attention: Yes/No Explain: _____

When did your child last see the doctor? _____ Why? _____

When did your child last see the dentist? _____ Why? _____

Allergies- Please list and describe allergies and reactions to:

Allergic To	Reaction Observed	Treatment
Medicine:		
Foods		
Insects/other		

Medications/Medical Procedures:

Daily Medications
Medications given frequently, but not daily
Procedures needed at school (sugar testing, etc.)
Accommodations requested at school due to a health concern or disability

PF1 adopted 2/09

Parent/Guardian Signature: _____ Date: _____