LOVING MUNICIPAL 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 school. The original form and any copies thereof may used to identify the medical options of the undersigned parent.

______________________	______________________	______________________	__________
School District	School Building	Home Room Teacher	Grade

Student's Full Name ____
Last First Middle SSN#

Student's Address ____
Street/Road P.O. Box/ Appt # City Zip Code

Student's Birth Date______________________________ Telephone________________________ Age_______

Student's Place of Birth______________________________ Ethnicity___________ Sex: Male_____ Female_____

Mother's Name ____ Daytime Phone______________________

Father's Name ____ Daytime Phone______________________

Guardian/Child Care Provider______________________________ Daytime Phone______________________

Guardian/Child Care Provider's Address____
Street/ Road P.O. Box/Apt # City Zip

Does the student ride the bus? Yes or No If yes, please indicate the bus number.___________

ALERNATE EMERGENCY CONTACTS (Local people to contact if parents cannot be reached.)

Name________________________________ Phone__________________ Relationship______________

Name________________________________ Phone__________________ Relationship______________

TO GRANT CONSENT

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

Doctor____ Phone______________________

Dentist____ Phone______________________

Nurse Practitioner/ Physical Assistant________________________________ Phone______________________

Hospital____ Phone______________________

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 provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concur or the needed.

Nothing in this section shall be constructed to impose liability on any school official or school employee who, in good faith, attempt 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 THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED

Please indicate if the student has had or is currently under treatment for any of the following conditions:

Give year or age when problem occurred.

________ASTHMA
________DIABETES
________EAR/ HEARING PROBLEM: (type)____
________EMOTIONAL PROBLEMS: (type) _________
________SEIZURES
________HEART PROBLEMS: (type)______
________HEPATITIS: (type)________
________OTHER: _____________
__________ALLERGIES?

_________MENINGITIS
_________MIGRAINE HEADACHE
_________MUSCULAR WEAKNESS OR PARALYSIS
_________BLEEDING DISORDER: (type)_________
_________HIGH BLOOD PRESSURE
_________INFECTIOUS DISEASE(type)__________
_________TETANUS SHOT: (date)_____________
________HEPATITIS B SHOT: (date)___________

_______ REACTION TO MEDICINE OR INJECTIONS?____

_______ HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY, OR ACCIDENTS? ____

_______ USE OF CONTACT LENS YES________ NO___________

_______ LONG TERM MEDICATIONS? ____

_______ HAVE YOU EVER BEEN INFORMED OF THE NEED TO BE ON ANTIBIOTIC THERAPY PRIOR TO DENTAL TREATMENT? YES_______ NO_________

IF YES, IDENTIFY REQUIRED THERAPY ____

_______ PLEASE ADD ANY PROBLEMS NOT LISTED____

Is student covered by health insurance? YES________ NO_________

Name of Insurance Company (Primary) ____

Subscriber's Name______________________________ ID Number or Group Number____

Does Medicaid cover student? YES________ NO_________

If yes, please indicate Medicaid I.D. Number_______________________________________

Does Children's Medical Service cover student? YES______ NO_________