



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	Mentor 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	_____ MENINGITIS
_____ DIABETES	_____ MIGRAINE HEADACHE
_____ EAR/ HEARING PROBLEM: (type) _____	_____ MUSCULAR WEAKNESS OR PARALYSIS
_____ EMOTIONAL PROBLEMS: (type) _____	_____ BLEEDING DISORDER: (type) _____
_____ SEIZURES	_____ HIGH BLOOD PRESSURE
_____ HEART PROBLEMS: (type) _____	_____ INFECTIOUS DISEASE (type) _____
_____ HEPATITIS: (type) _____	_____ TETANUS SHOT: (date) _____
_____ OTHER: _____	_____ HEPATITIS B SHOT: (date) _____
_____ ALLERGIES?	

_____ 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 _____

