HOME ROOM TEACHER'S NAME: _____ GRADE: _____ SCHOOL: _____

ARTESIA PUBLIC SCHOOLS HEALTH AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when a parent/guardian cannot be reached. Upon completion, this form must be returned to school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian.

PLEASE COMPLETE ALL THREE SECTIONS (front and back page).

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER: **M F**	DOB:

NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:

SECTION ONE: STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the **ER**, the school health office will always attempt to reach the Parent/Guardian listed below **FIRST**. Secondary contacts will be called if the parent/guardian cannot be reached.

PLEASE KEEP THESE NUMBERS CURRENT!

PARENT/GUARDIAN NAME:	ADDRESS	Phone #1
		Phone #2
Check all that apply: □ Lives With □ Legal Guardian		Phone #3
PARENT/GUARDIAN NAME:	ADDRESS	Phone #1
		Phone #2
Check all that apply: □ Lives With □ Legal Guardian		Phone #3

	Emergency Contact List	Relationship	Phone #1	Phone #2	Phone #3
1.					
2.					
3.					
4.					

SIBLINGS IN APS SCHOOLS

	NAME	SCHOOL	GRADE	DOB
1.				
2.				
3.				
4.				

*******NOTE: This is a two-sided document. Please complete back side of this form.*******

SECTION TWO: STUDENT HEALTH HISTORY – Please check appropriate box.

☐ **My child has no health conditions, including those listed below**

Allergies ☐ Seasonal ☐ Food (List): ☐ Other Allergy (List): ☐ HGas EpiPen prescription			
☐ ADD/ADHD	☐ CONGENITAL/GENETIC	☐ EAR/NOSE/THROAT	☐ PULMONARY OTHER THAN ASTHMA
☐ ASTHMA NEEDS INHALER AT SCHOOL: Y N	☐ EYE/VISION WEARS GLASSES/CONTACTS: Y N	☐ DIABETES (circle one) TYPE 1 TYPE 2	☐ CARDIOVASCULAR (LIST) _____ HIGH BLOOD PRESSURE : Y N
☐ CANCER	☐ DERMATOLOGIC/SKIN	☐ STOMACH/GI	☐ MUSCULOSKELETAL
LONG TERM MEDICATIONS (LIST):	☐ EATING DISORDER	☐ BLADDER/GU	☐ DENTAL/ORAL
	☐ ENDOCRINE OTHER THAN DIABETES	☐ HEMATOLOGY/BLEEDING DISORDERS ☐ MIGRAINES	☐ PSYCHIATRIC (LIST MEDS.):
☐ ANY OTHER HEALTH CONDITIONS:			

SECTION THREE: INSURANCE INFORMATION

STUDENT'S INSURANCE:	SUBSCRIBER'S NAME:	ID#

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

HEALTH CARE PROVIDER:	PHONE:
DENTIST:	PHONE:
HOSPITAL:	PHONE:

If, for any reason, NIETHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged 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. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I also understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done unless I provide the school health office with written notification requesting exclusion from these screenings.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____