

CEDAR UNIFIED SCHOOL DISTRICT #25

~~SCHOOL YEAR 2019-2020~~

**EMERGENCY AUTHORIZATION & MEDICAL INFORMATION**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Residential Address: \_\_\_\_\_

PARENT OR GUARDIAN TO CALL INCASE OF EMERGENY ILLNESS OR ACCIDENT

Mother/Guardian: \_\_\_\_\_ Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

PLEASE LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED.

1.	2.
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CHILD'S HEALTH HISTORY

*Please circle YES or NO*

Allergies	Yes	No	Anxiety	Yes	No	Arthritis	Yes	No	Asthma	Yes	No
Atten. Deficit Disorder	Yes	No	Bleeding Disorder	Yes	No	Behavior/Emotional Prob	Yes	No	Cancer	Yes	No
Cerebral Palsy	Yes	No	Chemical Abuse	Yes	No	Chest/Lung Condition	Yes	No	Counseling	Yes	No
Depression	Yes	No	Diabetes	Yes	No	Eating Disorder	Yes	No	Hearing Loss	Yes	No
Heart Condition	Yes	No	High Blood Pressure	Yes	No	Hypoglycemia	Yes	No	Kidney Problem	Yes	No
Learning Disabilities	Yes	No	Migraine Headaches	Yes	No	Pregnant	Yes	No	Restrictions	Yes	No
Seizure Disorder	Yes	No	Sinus Problems	Yes	No	Stomach Problems	Yes	No	Vision Deficit	Yes	No
Rheumatic Fever	Yes	No	Bone Fracture	Yes	No	Chicken Pox	Yes	No	Measles	Yes	No

If any YES circled, please comment: \_\_\_\_\_

Surgeries/Hospitalization or any other problems: \_\_\_\_\_

Does your child take daily medications(s)? Please circle YES or NO. If YIS list drug, dose and times (this includes inhalers): \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone# \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

1. I the undersigned do hereby authorize officials at Cedar School District #25 to contact directly the persons name on this form and do authorize the emergency room physician at Hopi Health Care Center to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event the persons named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child; I will not hold the Cedar School District financially responsible for the emergency care and/or transportation of said child.
2. I give the school nurse permission to examine my child at the school if he/she becomes ill or injured and provided necessary nursing treatment. In addition, I give permission for my child to participate in routine programs for vision, hearing, height, and weight, scoliosis and lice. I understand these services are part of school health programs throughout Arizona.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date