FRANKLIN MONROE LOCAL SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

urpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when arents or guardians cannot be reached.

tudent's Name: _____ Birthdate: _____ Teacher: _____ Grade: _____
Last First Middle

ome Address: _____

ity: _____ Zip: _____

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

ame & Address of Non-Residential Parent: _____

ist only the names (first and last) of those who have authority to make decisions in an emergency situation or who can pick up this student. Please nclude parent(s) contact information and emergency contact information below.

rder of Consent

1st _____ Home #: _____ Cell #: _____ Work #: _____ Relationship to Student: _____
Name

2nd _____ Home #: _____ Cell #: _____ Work #: _____ Relationship to Student: _____
Name

3rd _____ Home #: _____ Cell #: _____ Work #: _____ Relationship to Student: _____
Name

4th _____ Home #: _____ Cell #: _____ Work #: _____ Relationship to Student: _____
Name

(Please complete the reverse side of this form)

Franklin Monroe Schools Annual Health Review and Emergency Medical Authorization Form

Student Name:_____ **Birth Date:**_____ **Grade:**_____ **Teacher:**_____ **Date:**_____

Health Review: (Please check all that apply)

___Asthma	___Heart Surgery	___Migraines	___Stomach Problems/Ulcer	___Diabetes	___Orthopedic braces
___Reactive Airway Disease	___Fainting	___Seizures	___Bowel Problems	___Thyroid	___Mobility Impaired
___Heart Murmur	___Autism	___ADHD/ADD	___Urinary Problems	___Glasses	___Wheelchair

ALLERGIES: Food (i.e.: peanuts, milk, food dye)_____ Reaction:_____ **Environmental:**_____ Reaction:_____

Medicine:_____ Reaction:_____ Other:_____ Reaction:_____

LIFE THREATENING ALLERGIES: YES____ NO____ *****EPI-PEN Needed at School:** YES____ NO____

____ **NO MEDICAL CONCERNS AT THIS TIME**

List any emotional, social, or other health conditions that might affect your child's school performance: _____

Current Medications:_____ **Medications Given at School:**_____

Parent Authorization: Please read and give consent by signing: Consent and Release of Health Information: There may be occasions on which we need to contact your child's physician for health information or to clarify information. By signing below, I give my permission to contact them.

Doctor's Name: _____ **Phone:** _____

*****Parent/Guardian Signature:** _____ **Date:**_____

Please call the SCHOOL NURSE at your child's school whenever you have a concern or new information relative to your child's health.

Emergency Medical Authorization – PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and preferred hospital to be called:

Physician _____ Phone: _____

Dentist _____ Phone: _____

Medical Specialist _____ Phone: _____

Preferred Hospital _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent of (1) the administration of any treatment deemed necessary by above-named doctors, 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.

Signature of Parent/Guardian_____ Date:_____

PART II: REFUSAL TO CONSENT

I do **NOT** give my 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 actions:

_____

Signature of Parent/Guardian_____ Date:_____