**Allen County ESC ED/Alternative Program Emergency Medical Authorization Form**

_____ _____

Home School Student Name

_____

Address

_____

Telephone

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

**Residential Parent or Guardian**

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Child Care Provider _____

Relationship _____ Phone _____

Address _____

**Part I or Part II Must Be Completed**

**Part I (To Grant Consent)**

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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

Facts concerning the child's medical history including allergies, medications being taken, and physical impairments to which a physician should be alerted are: _____

Date _____ Parent/Guardian Signature _____

**********

**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. Instead, I wish the school authorities to take the following action:

_____

Date _____ Parent/Guardian Signature _____

Address _____

**PLEASE COMPLETE REVERSE SIDE. THANK YOU.**

Student Name _____ Birthdate _____ Age _____ Male ___ Female ___

Student Address _____ Grade _____ Homeroom Teacher _____

Student Social Security # _____

Check Transportation: ____Bus # ____(A.M.) Bus #____(P.M.) ____Taxi _____Parent ____ Other:

Mother's Name _____ Place of Employment _____ Phone _____

Father's Name _____ Place of Employment _____ Phone _____

Guardian's Name _____ Place of Employment _____ Phone _____

Name of Custodial Parent _____

Doctor _____ Phone _____

Dentist _____ Phone _____

If no home phone number, how can parent be reached? _____

If parent cannot be reached, who should be called for an emergency?

_____ Phone _____

Relationship to student: _____

If none of the above can be reached, what should the school do if the student is sick or injured?

_____

Current medications being taken: _____

Illness or injuries that the school should be aware of: _____

Is the student being treated at the present time? _____

Date of last tetanus immunization or booster: _____

**Allergies:**

**Food** _____

**Medication** _____

**Insect bites or stings** _____

Type of reaction: _____

**Hayfever/Asthma** _____

Has student had chicken pox? _____

Date _____

Family history of tuberculosis, diabetes, or other illnesses:

_____

Physical disabilities: _____

Operations/surgeries and dates: _____

_____

**Convulsions and type:** _____

Type of medication: _____

Has student been **re**-immunized for measles? _____ Date _____

List all school age and preschool children in the family:

| **Name** | **Age** | **Grade** | **Birthdate** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**PLEASE COMPLETE REVERSE SIDE. THANK YOU.**