One per child

ST. ANDREW- ST. ELIZABETH ANN SETON SCHOOL

2021-2022 EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. **Notify the school immediately if any information changes.** (Please print).

Student's Name_____ **Homeroom/Grade** _____

Student's Address_____ **Date of Birth** _____
(Street Address) (Zip Code)

Transportation (circle) Milford Bus CNE Bus Goshen Bus WC Bus Car Rider Extended Day

(Please check) Lives with: ___ Mother & Father ___ Mother Only ___ Father Only ___Shared Parenting ___ Other (list) _____

List the names, relationships to the student, and phone numbers of those people the school should call in the event of accident, illness, or school emergency. **This list should include the parent(s)/legal guardian(s) and should be in the order of calling preference, after attempts to call the parent(s)/guardian(s) are made.**

NAME	RELATIONSHIP	PHONE NUMBERS HOME	WORK	CELL/PAGER	e-mail
_____ (Parent/Legal Guardian)	_____	_____	_____	_____	_____
_____ (Parent/Legal Guardian)	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	

I understand that my child may be released to anyone on the above list if ill, injured, or if an emergency occurs, and he/she must leave school.

_____ _____
Signature of Parent/Legal Guardian **Date**

Medical Problems/Allergies/Special Needs:

Allergies: Medication or Food Allergy (list)_____

____ ADD/ADHD ____ Asthma ____ Bee or Insect Sting ____ Diabetes ____ Emotional Problems ____Headaches ____ Learning Disability ____ Orthopedic

____Seasonal Allergies ____ Seizures ____ Visually or Hearing Impaired ____Special Needs (explain)_____

____ Other Specific Health Considerations_____

MEDICATION(S) taken DAILY (please include those medications taken at home) _____

_____

MEDICATION(S) taken AS NEEDED_____

REASON FOR MEDICATION(S) _____

ARE MEDICATIONS GIVEN DURING SCHOOL HOURS? ☐ **YES** ☐ **NO**

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you do *not* consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

Doctor _____ **Phone** _____

Hospital (1st choice) _____ **(2nd choice)** _____

Dentist _____ **Phone** _____

Please complete EITHER Part I or Part II below:

Part I: Granting Consent

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

_____ _____
Signature of Parent/Legal Guardian **Date**

Part II: Refusal to Consent (DO NOT COMPLETE IF YOU COMPLETED PART I).

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 action: (MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)

_____ _____
Signature of Parent/Legal Guardian
Date

Please fill out this form completely and accurately to ensure all health information is readily available in case of an emergency.