Monte del Sol Charter School 2014-2015

EMERGENCY MEDICAL AUTHORIZATION FORM
CONTACT INFORMATION

Student

Last ______________________ **First** ______________________ **Middle Initial**: ________

Birthdate ___/___/___ **F / M** *(circle)* **Entering Grade** *(in August)* ______________________

SFPS ID ____________ *(lunch number)* **Student's cell phone number** ______________________

Mother

First name ______________________ Last Name: ______________________

Address ______________________ Apt# ________

City: ______________________ State: ________ Zip: ______________________

Home Phone ______________ Work Phone ______________ Cell ______________

Email ______________________

Employer ______________________

Father

First Name ______________________ Last Name ______________________

Address ______________________ Apt# ________

City: ______________________ State: ________ Zip: ______________

Home Phone: ______________ Work Phone ______________ Cell ______________

Email ______________________

Employer ______________________

Parent filling out this form (print name) ______________________

Two emergency contacts other than listed above (stepparent, grandparent, trusted family friend, etc.)

First Name ______________________ Last Name ______________________

Address ______________________ City ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Relationship to student: ______________________

First Name ______________________ Last Name ______________________

Address ______________________ City ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Relationship to student: ______________________

STUDENT: ***First*** ______________________________ ***Last*** ___________________________ ***Grade*** __________

MEDICAL HISTORY AND CONDITIONS: Please indicate if your child has had, or is currently under, treatment for any of the following conditions. Give description and date of illness or medical condition to which emergency medical personnel and the school nurse should be alerted:

ASTHMA __________________ ALLERGIES ___________________ BLEEDING DISORDER____________________

DIABETES _________________ EARS/HEARING PROBLEM _______________ HEPATITIS ____________________

EMOTIONAL PROBLEM _____________________________ HEART PROBLEMS _________________________________

HIGH BLOOD PRESSURE _________________________ INFECTIOUS DISEASES _____________________________

MENINGITIS __________________ MIGRAINE HEADACHES ____

MUSCULAR WEAKNESS/PARALYSIS: _____________________ SEIZURES _____________________________________

REACTIONS TO ANY MEDICATION OR VACCINATION ____

CURRENT OR LONG TERM MEDICATIONS *(please list)* ____

ANY HOSPITALIZATION, SERIOUS ILLNESS OR ACCIDENT? ____

CONTACT LENSES ? *Yes / No* GLASSES? *Yes / No* *OTHER EYE* PROBLEMS? *Yes / No* DATE OF LAST TETANUS SHOT _______

HAVE YOU EVER BEEN INFORMED OF THE NEED FOR AN ANTIBIOTIC BEFORE DENTAL TREATMENT? *Yes / No*

FURTHER DETAILS OR OTHER MEDICAL ISSUES *(use back of page if needed)* _______________________________

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§504 Disclosure of Disability: I believe that my child may have a disability that qualifies him/her for §504 accommodations and I request a review of his/her case. Suspected Disability: ____

INSURANCE or MEDICAID INFORMATION *Check if no insurance* _____________

Insurance company ________________________ ID # _____________________ Under which parent's name? __________________

TO GRANT CONSENT IN CASE OF EMERGENCY

In case of an emergency involving my child when I cannot be reached, I hereby give consent to transport my child to the following medical care providers or hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Doctor____ Phone: ________________________________

Dentist____ Phone: ________________________________

Hospital ____ Phone: ________________________________

If, for any reason, the listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to an appropriate medical care provider, hospital or urgent care facility. This authorization does not cover major surgery unless one other doctor or 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. ***I understand that I will be financially responsible for all emergency care.***

Parent/Guardian *(please print)* **First name** ___________________ **Last name** __________________________

Signature ____ **Date** ____________________________