CLEARVIEW LOCAL SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

Please complete both sides in *black or blue ink* and keep a copy for your records.
Remember to contact your child's school if information changes.

Last name _____ First name _____ Male __ Female __

Birthdate _____ Grade _____ School _____

Address _____ City _____ Zip_____

Home Phone _____ Student's Cell _____

CUSTODIAL PARENT/GUARDIAN INFORMATION: Please indicate which parent/guardian to call first, if applicable

[ ] Name _____ Cell Phone (___) _____ Work Phone (___)_____
[ ] Name _____ Cell Phone (___) _____ Work Phone (___)_____

Student resides with the following adults (circle all that apply):
mother father stepmother stepfather grandparent(s) guardian other _____
relationship

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardian cannot be reached. This does *not* allow person(s) below to take child out of school. Prior to each occurrence, parent must call the office or write a note giving permission for any person below to take child out of school for any reason (appointment, illness, etc.)

List the order in which you would like them contacted.

Name	Relationship	Home Phone	Work Phone	Cell Phone

EMERGENCY CARE

Doctor	**Phone**
Dentist	**Phone**
Medical Specialist	**Phone**
Local Hospital	**Phone**

COMPLETE EITHER PART I *OR* PART II BELOW (not both)

PART I: TO GRANT 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 above named doctors, or, in the event the designated 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

Do not complete if you have 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 take the following action: _____

_____

_____

_____
Signature of Parent/Guardian Date

(Complete Other Side)

STUDENT NAME _____

(Please print) **Last** **First** **(ID #)**

Your child's learning depends upon good health. Please complete this form with information you are comfortable sharing with the understanding that the more information provided, the better your child's learning environment can be enhanced. Health conditions currently affecting your child are of the greatest significance.

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

_____

_____

Allergies? Yes No To medications or seasonal/environmental? Please list _____
Has the allergy required emergency action in the past? Yes No
Comments_____

Bee sting allergy? Yes No Describe reaction_____
Difficult breathing? Yes No Emergency medication? Yes No

Peanut Allergy? Yes No Describe reaction_____
Difficult breathing? Yes No Emergency medication? Yes No
Do you eliminate all peanut-containing foods? Yes No
Comments _____

Asthma? Yes No Triggered by:_____ Treatment_____
Diagnosed by doctor:_____ Date _____

Diabetes? Yes No Date diagnosed_____ Type I ___ Type II ___
Takes insulin? Yes No Insulin Pump Yes No
Insulin Injection Yes No Insulin Pen Yes No

Epilepsy/seizures? Yes No Describe seizure_____
Date of last seizure_____ Medications_____
Is student currently under a doctor's care for seizures? Yes No

Heart condition? Yes No Describe_____
Activity restrictions? _____ Medications? Yes No

Bone/joint problem? Yes No Describe_____
Activity restrictions? _____

Please circle the following regarding health concerns that pertain to student:

Eyes: glasses: reading distance contacts Ears: frequent infections tubes hearing difficulty
lazy eyes crossed difficulty seeing hearing aid – right/left

Other:						
	ADD/ADHD	bladder	breathing	requires diapering	neurological	skin
	anxiety	blood disorder	catheterization	eating	nosebleeds/phobias	sleeping
	bedwetting	blood pressure	dental	headaches	OCD	special diet
	bi-polar	bowel	depression	menstruation	ODD	

Daily Medication: At Home? Yes No At School? Yes No Emergency Only? Yes No

Name of Medication _____ Reason for Taking? _____

Medication Information:

A. It is strongly recommended to parent, with their physician's counsel, that the medication schedule be adjusted to avoid administering medication during school hours.
B. If this is not possible, the Medication Request and Authorization Form must be filed with the respective building principal before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted on an annual basis.
C. Each prescribed medication, in the original container, shall have a pharmacist's label.

_____ _____

Signature of Parent or Legal Guardian Date