Emergency Medical Authorization

This form **MUST** be completed by the first day of school each year. A separate form must be completed for each child. Please print legibly.

REDEEMER CHRISTIAN SCHOOL 2018-2019

New Address? yes ☐ no ☐

Student Name_____ Primary Phone _____ Grade _____Birthdate_____

Address_____ City, Zip _____

First Contact

First Name _____

Last Name _____

Address _____

_____

Relationship: _____

Primary Phone _____

Cell / Work Phone (Please circle one)

_____

Email _____

Second Contact

First Name _____

Last Name _____

Address _____

_____

Relationship:_____

Primary Phone _____

Cell Phone _____

Work Phone _____

Email _____

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority.

Name	Relationship	Phone #1	Primary	Cell	Work	Phone #2	Home	Cell	Work
Name	Relationship	Phone #1	Primary	Cell	Work	Phone #2	Home	Cell	Work
Name	Relationship	Phone #1	Primary	Cell	Work	Phone #2	Home	Cell	Work

I give ( ) I do not give ( ) consent that the above named student may leave the Redeemer Campus after school dismissal without my expressed written or verbal consent to any faculty or staff member. Date:_____ Parent/Guardian Signature:_____

Complete only Part I OR Part II – not both!

Part I: To Grant Consent

I hereby give my consent for the administration of any treatment deemed necessary by the preferred physician, dentist, specialist and/or hospital listed below: OR in the event the designated preferred practitioner or hospital is not available, by another licensed physician or dentist or 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.

Physician _____ Phone _____ Medical Specialist _____ Phone _____

Dentist _____ Phone _____ Local Hospital _____ Phone _____

_____ _____

Signature of Parent / Guardian Date

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Part II: Refusal to Consent (DO NOT complete if Part I above is completed)

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:

_____

Signature of Parent / Guardian_____ Date_____ **Part III on the back of this form must be completed!**

Student Name_____ Grade _____

Part III: Medical History / Allergies / Medications

Medical History _____

Allergies_____ Medications_____

Health Conditions: The following information will be shared with the school nurse, medical assistant, your child's teacher(s) and the administration as necessary to assist in the safety and health of your child during school hours.

Please place a check beside any of the following that your child has had:

_____Abnormal spinal curvature
_____Allergies/hay fever
_____Anemia
_____Arthritis
_____Asthma
_____Behavior problems
_____Birth/congenital malformation
_____Blood disorder, type_____
_____Cancer, type_____
_____Chickenpox
_____Diabetes
_____Diarrhea or constipation (frequent)
_____Eczema
_____Emotional problems
_____Headaches (frequent)
_____Heart disease
_____Hypoglycemia
_____Kidney Disease
_____Learning disability
_____Lung disorder, type_____
_____Meningitis or Encephalitis
_____Orthopedic problems
_____Seizures/epilepsy
_____Sickle Cell Disease
_____Skin rashes (frequent)
_____Stool soiling
_____Throat infections (frequent)
_____Tics/nervous twitches
_____Urinary tract infections
_____Wetting (day_____, Night_____)

Does your child have a bee/insect or food allergy? Yes_____ No_____

If yes, explain the reaction_____

Does your child require an emergency injection such as an "Epi-pen" for his/her allergic reaction? Yes_____ No_____

Vision & Hearing:

Frequent ear infections? Yes_____ No_____ If yes, which ear?_____ Tubes currently in place? Yes_____ No _____

Reduction in hearing? Yes _____ No_____ If yes, which ear? _____ Last exam_____

Wears glasses? Yes _____ No_____ Contacts? Yes_____ No_____ Last exam _____

Medication:

Does your child require medication while at school? Yes_____ No_____
If yes, please fill out the appropriate forms

Grades 5-8 only, *Acetaminophen*, 500 mg tablets, ___Check here, if you ***do not*** what *Acetaminophen* given.
Or, give your child 1 tablet___ or ___ 2 tablets if requested? Tablets only, no liquid or chewable provided.

Please remember that if your child requires prescription or over-the-counter medications of any kind **during school hours**, you **will need to request** a medication form from the office which will require information and signatures from both a legal guardian and your child's physician. There is a specific law that allows for students to carry inhalers on their person if and only if the proper forms have been completed. For the most part, medications will be dispensed from the office. Medications of any type need to be delivered to the school in their original container with directions on the label matching the directions given by the physician on the medication form.

Limitations:

Does your child have any health problems that limit/interfere with school/gym activities? Yes_____ No_____
If yes, please explain_____
Please list any orthopedic, prostheses, or other assistive devices that your child needs during school hours_____

_____ _____
Signature of Parent / Guardian Date