EMERGENCY MEDICAL AUTHORIZATION FORM

PURPOSE: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

La Resolana Leadership Academy School District

N/A Home Room Teacher

Grade

Student's Full Name _____
Last First Middle Social Security #

Student's Address _____
Street/Road P.O. Box/Apt # City Zip Code

Student's Birth Date _____ Telephone ( ) _____

Mother's Full Name _____ Daytime Phone ( ) _____

Father's Full Name _____ Daytime Phone ( ) _____

Guardian or Child Care Provider _____ Daytime Phone ( ) _____

Guardian or Child Care Provider's Address _____
Street/Road P.O. Box/Apt # City Zip

ALTERNATE EMERGENCY CONTACTS (Local people to contact if parents cannot be reached)

1. Name_____ Phone_____ 2. Name_____ Phone _____

INSURANCE INFORMATION

Student's Insurance (primary) _____ Subscriber's Name_____ ID Number_____

TO GRANT CONSENT

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

Doctor _____ Phone ( ) _____

Dentist _____ Phone ( ) _____

Nurse Practitioner/Physician Assistant _____ Phone ( ) _____

Hospital _____ Phone ( ) _____

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

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

-Complete Form on Other Side-

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED

Please indicate if student has had or is currently under treatment for any of the following conditions:

Give year or age when problem occurred.

_____**ASTHMA**
_____**DIABETES**
_____**EAR/HEARING PROBLEMS: (type)**_____
_____**EMOTIONAL PROBLEMS: (type)**_____
_____**SEIZURES**
_____**HEART PROBLEMS: (type)**_____
_____**HEPATITIS: (type)**_____
_____**OTHER:** _____

_____**MENINGITIS**
_____**MIGRAINE HEADACHES**
____ **MUSCULAR WEAKNESS OR PARALYSIS**
____ **BLEEDING DISORDERS: (type)**_____
_____**HIGH BLOOD PRESSURE**
_____**INFECTIOUS DISEASES: (type)**_____
_____**TETANUS SHOT: (date)**_____

_____**ALLERGIES?** _____

_____**REACTIONS TO MEDICINE OR INJECTIONS?** _____

_____**HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS?** _____

_____**USE OF CONTACT LENSES? YES**_____ **NO** _____

_____**LONG TERM MEDICATIONS?** _____

_____**HAVE YOU EVER BEEN INFORMED OF THE NEED TO BE ON ANTIBIOTIC THERAPY PRIOR TO DENTAL TREATMENT?**

YES _____ **NO** ____ **IFYES, IDENTIFY REQUIRED THERAPY** _____

_____**PLEASE ADD ANY PROBLEMS NOT LISTED** _____