WEST CARROLLTON SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

Complete all areas in black ink. Press HARD.

Student Birthdate: _____ Grade: _____ Gender: M F Student name: _____

BUS #: _____ Teacher: _____ Building: _____ Primary Phone: _____

Address: _____City: _____ Zip: _____

Select ONE of the following options regarding State-requested, student Military status info, as it applies to your child:

_____ A-Active Duty (Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)
_____ B-National Guard (Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard)
_____ C-Reserves
_____ Not Applicable (Not a Military Student)

Parent / Legal Guardian Information (please indicate IF listing step-parents):

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Home #: _____ Cell #: _____

Mother's Email: _____@_____ Father's Email: _____@_____

Employer: _____ Work #: _____ Employer: _____ Work #: _____

Emergency contacts we may release your child to: (will call in order if parent/guardian **CAN NOT** be reached)

1. Name: _____ Relationship: _____ Phone: _____ Cell: _____

2. Name: _____ Relationship: _____ Phone: _____ Cell: _____

HEALTH INFORMATION – LIST HEALTH INFORMATION SCHOOL PERSONNEL SHOULD BE AWARE OF:

Allergies: No ____ Yes ____ Specify _____(***Food allergy requires doctor statement)***

Epi-pen: No ____ Yes ____ ***If yes, Epi-pen Medication Authorization Form must be completed.***

Asthma: No ____ Yes ____ ***If yes, Inhaler Medication Authorization Form must be completed.***

Seizures: No ____ Yes ____ Name(s) of seizure medications? _____

Diabetes: No ____ Yes ____ Name(s) of diabetic medications? _____

Does your student take any medication regularly? No ____ Yes ____ Specify _____

Will your student take medication at school? No ____ Yes ____ ***If yes, Medication Authorization Form must be completed.***

Are there any other medical conditions that school personnel should be aware of? _____

Parent/Legal Guardian signature is required to authorize above health information can be shared with school personnel:

Parent/Legal Guardian Signature: _____ Date: _____

CONSENT CONSENT CONSENT CONSENT

I **DO GIVE PERMISSION** for emergency treatment of my child, if a parent/guardian cannot be reached. This permission does not cover major surgery, unless the medical opinions of two licensed physicians or dentists concur prior to the performance of such surgery.

Parent/Guardian signature _____ **Date** _____

Preferred Doctor _____Phone_____

Preferred Hospital _____ Phone_____

Preferred Dentist _____Phone_____

REFUSAL REFUSAL REFUSAL REFUSAL

I **DO NOT GIVE PERMISSION** for emergency treatment of my child. In the event my child needs emergency treatment, I wish the school authorities to take the following action: _____

Parent/Guardian signature _____ Date _____