

Aldo Leopold High School
Emergency Medical Authorization Form

Student's Name _____ Grade _____ Phone _____

Address _____ City _____ Zip _____

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 or guardians cannot be contacted. This form will accompany student on all field trips.

Mother's name _____ Phone #s Home _____ Work _____ Cell _____

Father's name _____ Phone #s Home _____ Work _____ Cell _____

Alternative emergency contacts: (Local people to contact if parents cannot be reached; and have your permission to check out your child or make medical decisions.)

Name _____ Phone _____ Relationship _____

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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 _____

Hostipal _____ Phone _____

Student Medical Insurance _____ Plan/Group/I.D. Number _____

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transportation and medical care of my child to any appropriate medical care provider, hospital, or medical facility. I authorize ALHS personnel to make necessary decisions and take appropriate actions in emergency situations on behalf of my student. The authorization does not cover major surgery unless one other doctor/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. It is understood that I will be financially responsible for all emergency care.

May this student receive Over-the-counter Medications? _____

I give my child permission for to participate in water activities under adult supervision. YES or NO

I give my child permission to participate in kayaking activities. YES or NO

Signature of Parent/Guardian _____ Date _____

2009-2010 Health History

Student Name _____ D.O.B. _____ Grade _____

Health Issues: Check any health issues pertaining to your child.

- | | |
|---|---|
| <input type="checkbox"/> Allergies (list below) | <input type="checkbox"/> Heart Disease or surgery |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Birth defects/congenital malformations | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin rashes (frequent) |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Throat infections |
| <input type="checkbox"/> Diarrhea or constipation (chronic) | <input type="checkbox"/> Tics/nervous twitches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Dietary Restrictions | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Other |

Please explain any issue checked above in as much detail as possible.

Vision glasses contacts

Hearing Any loss of hearing or disease? Which ear?

Frequent ear infections Which ear? How often?

Serious Illness, Injury, Surgery, Hospitalizations

Medications – List Name and dosage of any medications being taken this year at home or school

Other Concerns – Please explain below.

Social _____ Behavioral _____

Emotional _____

