HEALTH AUTHORIZATION FORM

PURPOSE: The enable parents/guardians to AUTOHORIZE emergency treatment for a child who becomes ill or injured while under school authority when parents cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian.

Student's LAST NAME	Student's FIRST NAME	Middle	Gender	DOB

In the event you child becomes sick or injured and needs to be sent home or to the ER, the school health official will always attempt to reach the Parent/Guardian listed below **FIRST**. Secondary contacts will be called if the parent/guardian cannot be reached. **PLEASE KEEP THESE NUMBERS CURRENT**

Parent/Guardian 1 Name	Address	Home/Cell#	Work#
Check all that apply:	☐ **Legal Guardian**	☐ **Lives With**	

Parent/Guardian 2 Name	Address	Home/Cell#	Work#
Check all that apply:	☐ **Legal Guardian**	☐ **Lives With**	

Does this student have special needs? ☐ Yes ☐ No

If answered YES to above question, please select one below and explain.

☐ IEP _____ Copy to Special Services? ☐ Yes ☐ No

☐ 504 _____ Copy to Coordinator? ☐ Yes ☐ No

☐ Court Order Protection ☐ Yes ☐ No Yes? Against:

If your child needs to take prescription meds or over the counter meds at school, please have their Dr. fill out the Medication Nursing Procedure Authorization Form. Ask health assistant for a copy.
Students may not carry any type of meds with them at school without med auth form.

☐ **My child has NO health conditions including those listed below.**

☐ Allergies: Seasonal

☐ Allergies: Food (list): _____

Other allergies (list): _____

Medical Contitions – Check all that apply

☐ ADD/ADHD Do they take meds? ☐ Home ☐ School

☐ Asthma (Have an asthma action plan?) Need inhaler at school? ☐ Yes ☐ No

☐ Cancer Do they take meds? ☐ Home ☐ School

☐ Congenital/Genetic Do they take meds? ☐ Home ☐ School

HEALTH AUTHORIZATION FORM

☐ Eye/Vision (Wear glasses, hearing aides?)	Do they take meds? ☐ Home ☐ School
☐ Dermatologic/Skin	Do they take meds? ☐ Home ☐ School
☐ Eating Disorder	Do they take meds? ☐ Home ☐ School
☐ Endocrine other than Diabetes	Do they take meds? ☐ Home ☐ School
☐ Ear/Nose/Throat	Do they take meds? ☐ Home ☐ School
☐ Diabetes	☐ Type 1 ☐ Type 2; Do they take meds? ☐ Home ☐ School
☐ Stomach/GI	Do they take meds? ☐ Home ☐ School
☐ Bladder/GU	Do they take meds? ☐ Home ☐ School
☐ Hermatology/Bleeding Disorder	Do they take meds? ☐ Home ☐ School
☐ Migraines	Do they take meds? ☐ Home ☐ School
☐ Pulmonary (other than Asthma)	Do they take meds? ☐ Home ☐ School
☐ High Blood Pressure	Do they take meds? ☐ Home ☐ School
☐ Musculoskeletal	Do they take meds? ☐ Home ☐ School
☐ Dental/Oral	Do they take meds? ☐ Home ☐ School
☐ Psychiatric (Telehealth/counceling meetings?)	Do they take meds? ☐ Home ☐ School

This will also serve as authorized people who can pick up your child. If someone comes in and they are not on this list they will not be able to pick up your child.

EMERGENCY CONTACT INFO

	Name	Phone Number	Relationship
Contact #1:			
Contact #2:			
Contact #3:			
Contact #4:			

In case of emergency and if we are unable to locate you or your emergency contact, do you give the school or emergency personnel permission to treat your child – including transporting your child by ambulance, if needed? ☐ Yes ☐ No

INSURANCE INFORMATION

Student's Insurance	Subscribers Name	ID #

In case of emergency involving my child and **I CANNOT BE REACHED**; I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care.

Health Care Provider	Phone #
Dentist	Phone #
Hospital	Phone #

HEALTH AUTHORIZATION FORM

If, for any reason, **NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED**, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital, or medical facility. This 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. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature _____ Date _____