DELAWARE CITY SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

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 reached. This information may be shared with persons responsible with the care of my child.

Student's Name: _____ Birthdate:_____ Grade:_____

Home Address:_____ Teacher/Homeroom: _____

City/State/Zip:_____ Date of Last Tetanus:_____

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other:_____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

___ Mother: _____ Home#:_____ Work#: _____

___ Father: _____ Home#: _____ Work#: _____

___ Stepparent: _____ Home#: _____ Work#: _____

___ Guardian: _____ Home#: _____ Work#: _____

___ Relative or alternate (i.e., child care provider), if applicable: Relationship to Child: _____
Name: _____ Home#: _____ Work#: _____

COMPLETE <u>ONLY ONE</u> OF THE FOLLOWING: **I**. Consent for Treatment **OR** **II**. Refusal to Consent

I. CONSENT FOR TREATMENT:

I hereby give consent for the following medical care providers and local hospital to be called:

*Preferred Physician:*_____
Office #:_____
*Preferred Dentist:*_____
Office #:_____
*Medical Specialist:*_____
Office #:_____
*Preferred Hospital:*_____
ER #:_____

AND

II. REFUSAL TO CONSENT:

I do **<u>NOT</u>** 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:

_____
_____
_____
_____

Parent/Guardian
Signature:_____
Address:_____
_____
Date:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to 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.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted: _____

_____

Parent/Guardian Signature: _____ Date:_____

(Please complete other side)

Medical History – Please check any that this child has had:

- ☐ Abnormal spinal curvature (scoliosis, etc.)
- ☐ ADHD/ADD
- ☐ Allergy
- ☐ Anemia
- ☐ Asthma or wheezing
- ☐ Bedwetting at night _____ during day _____
- ☐ Behavior problems
- ☐ Birth defect
- ☐ Cancer, type _____
- ☐ Chicken Pox
- ☐ Chronic diarrhea or constipation
- ☐ Chronic cough
- ☐ Concern for relations with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Emotional/depression/anxiety disorder
- ☐ Ear problems, poor hearing
- ☐ Eating disorders
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent skin infections
- ☐ Frequent sore throat infections
- ☐ Heart disease, type _____
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Joint problems or arthritis
- ☐ Kidney disease, type _____
- ☐ Near drowning/suffocation
- ☐ Nervous twitches or tics
- ☐ Painful menstrual cramps
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures or epilepsy
- ☐ Self hurt behaviors
- ☐ Sickle cell anemia
- ☐ Stool Soiling (encoporesis)
- ☐ Substance abuse (alcohol/drugs)
- ☐ Suicide attempt
- ☐ toothache or dental infections
- ☐ Urinary tract infections
- ☐ Other _____
- ☐ Other _____

During the past 3 years:

Any hospitalizations: Yes/No Explain: _____

Any illness lasting more than a week: Yes/No Explain: _____

Any injuries requiring medical attention: Yes/No Explain: _____

When did your child last see the doctor? _____ Why: _____

When did your child last see the dentist? _____ Why: _____

Allergies – Please list and describe allergies and reactions to:

Allergic To	Reaction Observed	Treatment (Benadryl, Epi-Pen, 911)
Medicine:		
Foods		
Insects/other		

Medications/Medical Procedures:

Daily Medications:
Medications given frequently, but not daily:
Procedures needed at school (sugar testing, etc.)
Accommodations requested at school due to a health concern or disability: