CRICKET

HEALTH ALERT ☐

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 the educational team to best meet your child's needs.

Student Name ______________________ Phone # ______________ Bus # __________

Address ______________________ School District ______________________

______________________ School Attending ______________________

Address Change Y N Birth Date ______________ Sex M F Grade ____ Home Room ______________

Residential Parent or Guardian

Mother ______________ Day Ph # ______________ Cell # ______________

Email ______________________ Pager # ______________

Father ______________ Day Ph # ______________ Cell # ______________

Email ______________________ Pager # ______________

Other Name ______________ Day Ph # ______________ Cell # ______________

Name of Relative or Childcare Provider ______________________

Address ______________________ Phone # ______________

______________________ Relationship ______________

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

Doctor ______________________ Phone # ______________

Dentist ______________________ Phone # ______________

Medical Specialist ______________________ Phone # ______________

Hospital ______________________ Phone # ______________

Below check any current health condition that may require attention during the school day:

- ☐ Allergies (be specific)
  - ☐ Foods ______________
  - ☐ Medicines ______________
  - ☐ Bee Stings ______________
  - ☐ Other ______________
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing problems ☐ Hearing aid(s)
- ☐ Heart problems (be specific) ______________
- ☐ Surgeries (include year) ______________
- ☐ Concussion/head injury — year ______________
- ☐ Physical disability (be specific) ______________
- ☐ Respiratory (be specific) ______________
- ☐ Seizures ______________
- ☐ Vision problems (be specific) ______________
  - ☐ Glasses ☐ Contacts
- ☐ ADD/ADHD
- ☐ Behavior/emotional problems ______________
- ☐ Other (be specific) ______________

List all medications and dosages your child receives on a continual basis:

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PLEASE COMPLETE PART I *OR* PART II — NOT BOTH

Part I — TO GRANT CONSENT

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 designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date ______________ Parent or Guardian Signature ______________________

Part II — REFUSAL TO CONSENT

I do not 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 no action or to: ______________________

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Date ______________ Parent or Guardian Signature ______________________

Revised 4/07