

**Ironton City Schools
Emergency Medical Authorization Form**

Medical Alert _____

Grade/Class _____

Name _____ SS# _____ Date of Birth _____

Address _____

Parent(s)/Guardian Name(s) _____

*Home # _____ *Mobile # _____ Father's Work _____

Mother's Work # _____ Email Address: _____

(* Denotes the telephone #s that will be used to contact parents in the event of school delays/cancellations. All numbers listed will be used to contact the parent/guardian in case of an emergency.)

Is this student Hispanic or Latino? **(Circle One)** Yes No

What is the student's race? **(Circle All That Apply – But At Least One)**

White Black Asian American Indian/Alaskan Native Native Hawaiian/Pacific Islander

List in order the person to contact and/or person to pick up student when parents/guardians cannot be reached. (Students will not be released to anyone whose name is not on the emergency card, and ID must be shown if asked.)

1. Name _____ Phone _____

Address _____ Relationship _____

2. Name _____ Phone _____

Address _____ Relationship _____

Physician _____ **Hospital Name** _____
Name/Telephone # _____

Dentist _____
Name/Telephone # _____

HEALTH HISTORY

Has your child had or currently have any of these problems listed? **If yes, please give details and list medications below**

√	CHECK or CIRCLE EACH ITEM
	List Allergies: Meds or Food
	Benedryl???
	Epi-pen???

Asthma - Inhaler???
Diabetes – Insulin/Glucagon
Seizures - Meds.???
ADD (Attention Deficit) Meds.???
ADHD (Hyperactive Disorder)
Bowel Problems?? - List
Headaches – Meds.???

Hearing Problems/Ear Tubes
Vision Problems-Glasses/Contacts
Urinary problems?? - List
Other Problems - Surgeries

MEDICATION: (List each medication and reason for taking including any over-the-counter medication – Please specify)		
Medication - Dose -Times Taken	Reason for Taking	At School???

DO YOU NEED TO TALK TO A SCHOOL NURSE FOR ANY SPECIAL NURSING NEEDS FOR THIS STUDENT? YES NO

COMMENTS _____

PART I: 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 above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician; 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 of such surgery, are obtained prior to the performance of such surgery.

Date _____ **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 the following action:

Date _____ **Signature** _____