

**Ironton City Schools
Emergency Medical Authorization Form**

Medical Alert _____

Grade/Class _____

Name _____ SS# _____ Date of Birth _____

Address _____ Phone # _____

Parent(s)/Guardian Name _____ Additional Phone # _____

Mother's Work # _____ Father's Work # _____

**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 _____

3. Name _____ Phone _____
Address _____ Relationship _____

Physician _____ Hospital _____

Physician Address _____ Phone _____

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 |
| | |
| | |
| | |
| | Epi-pen??? |
| | Benedryl??? |
| | |

| | |
|--|----------------------------------|
| | 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 |
| | |
| | |
| | |
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| | |
| | |

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 _____ Revised 7/2009