For office use

Arcanum Butler Local School District
Emergency Medical Authorization Form

Mark one: ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 _____ (Homeroom Teacher) (K-5 only)
☐ 6 ☐ 7 ☐ 8
☐ 9 ☐ 10 ☐ 11 ☐ 12

Student Information

Last name _____ First name _____ Telephone _____

Address _____ City _____ Zip _____

Date of birth _____ Social security number _____-_____-_____

Residential Parent/Guardian Information

Name _____ Daytime location _____

Daytime/cell phone, if different from above _____

Name _____ Daytime location _____

Daytime/cell phone, if different from above _____

Other Parent/Guardian with Authorization to Consent for Care

Name _____ Address _____

Daytime location _____ Daytime/cell phone _____

You must complete either PART 1 or PART 2 below. *Purpose: To enable parents and/or 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 side will be used during school hours and for authorized school activities including field trips.*

PART 1: 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 following health care providers, or if the designated preferred practitioner is not available, by another licensed healthcare provider or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Primary Care Provider _____ Telephone _____
Dentist _____ Telephone _____
Local Hospital _____ Telephone _____

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. The following are facts concerning the child's medical history, including allergies, medications being taken and any physical impairments or chronic conditions to which a physician should be alerted:

_____

Signature of Parent/Guardian _____ Date _____

PART 2: 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:

_____

Signature of Parent/Guardian _____ Date _____

Continued on other side

TELEPHONE CALLING ORDER. During the course of the school year there are times when a student may need to leave school due to illness or communicable disease requiring transportation home. Parents or guardians may not be available during these times. Students who are ill must be dismissed to a responsible adult. Please list below the names and contact numbers of five adults (including yourself as parent/guardian) who you would prefer for us to call in case of an illness or emergency. Please put these names in the order of who should be called first, second, etc. Please notify the school when telephone numbers change.

Name	**Relationship**	**Daytime and/or cell phone**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

MEDICAL INFORMATION. In order to help us plan for a safe and healthy school experience for your child, please check any of the following that currently apply to this student:

- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Drug or alcohol use
- ☐ Cancer
- ☐ Eating disorder, anorexia, bulimia, obesity
- ☐ Epilepsy/seizures
- ☐ Has a cast, brace, wheelchair or other supportive or assistive device
- ☐ Heart condition
- ☐ Life threatening allergies (anaphylaxis) _____
- ☐ Food or other allergies (non-life threatening) _____
- ☐ Medication during the school day
- ☐ Mental health concerns
- ☐ Other _____
- ☐ Smoking
- ☐ Wears a hearing aid
- ☐ Wears corrective lenses (glasses or contacts)
- ☐ Wears prosthesis
- ☐ My child has special healthcare needs. Please have the school nurse contact me to develop a school-based health plan.

The space below is provided for you to list any <u>additional</u> information concerning your child's health or medical conditions of which the school staff should be aware.

_____

I give permission to share this health information with school staff as needed. ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____