DELPHOS CITY SCHOOLS: BUILDING _____

EMERGENCY MEDICAL AUTHORIZATION

School Year: _____ **Grade:** _____

Student's Name: _____ **Date of Birth:** _____ **Bus #** _____

Student's Address: _____ **Home Telephone:** _____

_____ **County of Residence:** _____

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.
Please contact the school office if any of this information changes throughout the school year.

Parents:	**Mother** -	**Father**	**Siblings Name**	**Age**
Name:				
Address:				
Home Phone:				
Cell Phone:				
Employer:				
Work Phone:	**Ext**	**Ext**		
Work Hours:				
Email:				

Parents: Married ☐ Divorced ☐ Separated ☐ Other ☐ Other, please specifiy _____

If divorced/separated/other, who is residential parent?

_____

Official paperwork must be on file in the school office

Is someone other than parent the legal guardian? Yes ☐ No ☐

If Yes: Name: _____ Address: _____

Phone: _____ _____

Military Status of Parent/Guardian

☐ Not applicable

☐ Active Duty Member (Army, Navy, Air Force, Marines or Coast Guard)

☐ National Guard Member (Army or Air)

☐ Reserves

If your child becomes ill during the school day and you cannot be reached, please list the persons you wish notified to pick your students up.
Please list as many as possible

Name: _____ **Phone #** _____ **Relationship** _____

Name: _____ **Phone #** _____ **Relationship** _____

Name: _____ **Phone #** _____ **Relationship** _____

FIELD TRIP PERMISSION: _____ (student name) has my permission to go with a school chaperoned group on field trips away from the building.

Parent/Guardian Signature: _____

PUBLIC RELEASE INFORMATION

The Delphos City Schools have permission to use my child's name and photograph in any school related news releases to area newspapers, radio, television, school web pages or other school publications or any other lawful purpose.

Yes ☐ No ☐

Student Name: _____

Parent/Guardian Signature: _____

Student Signature if 18 or older: _____

(Please complete both sides)

PART I OR II MUST BE COMPLETED

MEDICAL

PART I

I hereby give consent for the following medical care providers and local hospital to be called in the event all reasonable attempts to contact me have been unsuccessful:

Doctor's Name: _____ **Phone #** _____

Dentist's Name: _____ **Phone #** _____

Medical Specialist: _____ **Phone #** _____

Local Hostpital: _____ **Phone #** _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) 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 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 performances of such surgery.

All medical information provided on this form and through conversations and documentations with the school nurse, will be shared with staff members who will be supervising my child (including but not limited to, school secretary, school principal, school nurse, physical education teacher, music teacher, bus driver, speech therapist and/or guidance counselor). I understand that by signing this form, I am allowing the stated medical information to be provided to pertinent staff members in the Delphos City School District.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted are as follows:

Food Allergies: _____ Physical Disabilities: _____

Medication Allergies: _____ Operations/Surgeries & Dates: _____

Insect Bites or stings: _____ Convulsions and Type: _____

Type of Reaction: _____ Physical impairments &/or Blood borne pathogen disorder:
(heart, diabetes, thyroid, immune-deficiency, hepatic HIV/AIDS
Hayfever/ Asthma _____ hearing, vision, congenital (born with) _____

Has Student had Chicken Pox? _____ _____

Behavioral/Psychological (Turret's ADD/HD, ODD, Depression, Eating Disorder (if applicable) _____

_____

All other pertinent medical information _____

All medications my child is currently taking _____

My child will require medication at school (list name, dosage, time) _____
(ADDITIONAL FORM WILL NEED TO BE COMPLETED AND ON FILE IN THE CLINIC TO ADMINISTER MEDICATION AT SCHOOL.)

Date: _____ **Signature of Parent/Guardian:** _____

PART II DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 actions:

_____

_____

Date: _____ **Signature of Parent/Guardian:** _____