UNIT SEVEN SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

NAME: _____ GRADE/TEACHER: ____/ _____

ADDRESS: _____

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 in a timely manner. Every effort will be made to provide medical services as needed and as designated below.

** List parent{s} first and then list family or friends as #3 & 4. You may **not** exclude a parent if there is joint custody of the child, unless you show court documentation of sole custody belonging to either parent.

Mother: _____ Home #: _____
Cell: _____ Work: _____

Father: _____ Home #: _____
Cell: _____ Work: _____

#3. Name: _____ Relationship: _____ Home #: _____
Cell: _____ Work: _____

#4. Name: _____ Relationship: _____ Home #: _____
Cell: _____ Work: _____

If unable to reach me at any of the above telephone numbers, I hereby give my consent for necessary treatment by Dr. _____ at phone number: _____, our preferred physician, or, if not available, by another licensed physician. I prefer treatment at _____ hospital.
This Emergency Medical Authorization shall continue in full force and in effect until CUSD #7 is advised in writing of any changes desired by the undersigned. I understand that any expenses incurred as a result of transportation and/or treatment will be my financial responsibility.

_____ _____
Signature of Parent or Legal Guardian **Date**

HEALTH CONCERNS: (may continue on reverse side of form if needed)

_____

_____

_____

_____

ALLERGIES:

_____

Community Unit School District No. 7 –

HEALTH INFORMATION FORM

Student's name	Date of birth	Teacher / Grade
Doctor's name	Doctor's phone number	

Check the box if your child has a history of any medical problems, illnesses, or allergies.

- ☐ Asthma — Triggered by? _____ How often? _____ Uses inhaler ☐ yes ☐ no Uses nebulizer ☐ yes ☐ no
- ☐ Seizures — Describe: _____ Date of last seizure: _____
- ☐ Heart Condition — Describe: _____
- ☐ Diabetes — Takes insulin ☐ yes ☐ no
- ☐ Stomach problems — Describe: _____
- ☐ Frequent headaches — Migraines? ☐ yes ☐ no
- ☐ Frequent strep throat
- ☐ Frequent nosebleeds
- ☐ Frequent ear infections — History of tubes ☐ yes ☐ no
- ☐ Visual problems — Glasses ☐ Contact lenses ☐
- ☐ Hearing problems — Hearing aids? ☐ yes ☐ no
- ☐ Speech problems — Describe _____
- ☐ Allergies:
  - Food _____
  - Insects/Animals _____
  - Medicine _____
  - Environmental _____
  - Other _____

**Does your child have EMERGENCY medication for this allergy that needs to be kept in the nurse's office at school? (Usually an Epi-Pen) ☐ yes ☐ no

- ☐ Attention Deficit Disorder
- ☐ Physical limitations or disabilities Describe: _____
- ☐ Activity restrictions Describe: _____
- ☐ Has your child ever been hospitalized or had surgery? Describe: _____

****Medication(s) child is currently taking****

Name of medication	Reason for taking the medication	Child takes medication at: Home	School	Emergency
1. _____	1. _____	☐	☐	☐
2. _____	2. _____	☐	☐	☐
3. _____	3. _____	☐	☐	☐

Please list any other special concerns that you have about your child's health: (use back of sheet if necessary)

I consent that information on this form may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature	Relationship to student	Date