

**St. Joseph Consolidated School**  
**Emergency Medical Authorization Form**

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Purpose- To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached. **One form for each student must be filled out.**  
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Student Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Part I or Part II MUST be completed**  
**Part I (To Grant Request)**

Physician Name: \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital Emergency Room \_\_\_\_\_

In the event reasonable attempts to contact me have not been successful. I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named physician or dentist or in the event designated the preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to any hospital reasonably accessible.

The 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.

List any facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be noted on the reverse side of this form.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**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 medical treatment, I wish the school authorities to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**St. Joseph Consolidated School  
Medical Information Form**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

**I. ALLERGIES**

A. Environmental or Animal

List any medicines taken (prescription or over the counter)

\_\_\_\_\_

B. Food Allergies (please circle any that apply)

- |                                       |                               |
|---------------------------------------|-------------------------------|
| 1. Peanuts or other nuts              | 3. Red dye or other food dyes |
| 2. Milk Allergy or Lactose Intolerant | 4. Citrus Fruits              |

C. Medicine Allergies (please circle any that apply)

- |                 |                       |
|-----------------|-----------------------|
| 1. Amoxicillin  | 7. Pediazole          |
| 2. Augmentin    | 8. Penicillin         |
| 3. Bactrim      | 9. Sulfa Drugs        |
| 4. Ceclor       | 10. Suprax            |
| 5. Codeine      | 11. Others not listed |
| 6. Erythromycin |                       |

D. Latex or Medical Tapes (please circle)

E. Bee stings or other insect bites (please circle)

**II. Medical Conditions (Please circle those that apply)**

- |  |   |  |
|--|---|--|
| A. Asthma (inhaler Yes or No)              | F. Hereditary Spherocytosis             | J. Nisson Funderpection                                  |
| B. Broken bones in last 12 months<br>_____ | G. Kidney or Bladder problems           | K. Orthodontic appliances (Please list _____)            |
| C. Contacts or glasses                     | H. Migraines (List any meds given_____) | L. Tubes in Ears (If in last year please list date_____) |
| D. Diabetes                                | I. Motions Sickness                     |  |
| E. Eczema                                  |   |  |

**Please take some moments and list any other medical conditions that may be of concern for the safety of your child.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

