SAINT ALBERT THE GREAT SCHOOL

104 WEST DOROTHY LANE • KETTERING, OHIO 45429-1487 AREA CODE 937 • PHONE 293-9452

Emergency Authorization (Updated Annually) Page 1 of 2

Last:	First:		Middle:
Gender: ☐ Male ☐ Female	Height:	Weight:	Birthdate:
Teacher:	Grade:	Home Phone:	
Address:			
Father's Name:		Work or Day Phone:	
Cell:		Email:	
Mother's Name:		Work or Day Phone:	
Cell:		EMAIL:	
Legal Guardian:	Student Lives With (include relationship):		

Instructions: Parent/Guardian to complete either **Part I** or **Part II** of this form and return to your child's school within 10 days after you receive it.

Purpose: To enable parent(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardian cannot be reached.

PART I or PART II MUST BE COMPLETED

PART I – Grant Consent

In the event that reasonable attempts to contact me (at the above numbers) 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 provider is not available, by another licensed health care provider or dentist; (2) the transfer of the child to any hospital reasonably accessible.

Health Care Provider/Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Preferred Local Hospital _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physician or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history (include allergies, medications being take, and any physical impairments to which a health care provider should be alerted): _____

_____

_____

Date: _____ Parent Signature: _____

PART II – Refusal to Consent (DO NOT complete if you have completed Part I)

I do not give consent of emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that school authorities take no action or to: _____

_____

_____

Date: _____ Parent Signature: _____

Emergency Authorization Continued Page 2 of 2
Health Information (Updated annually)

Student's Name: _____ **Grade:** _____ **Rm.** _____

Additional emergency numbers if parents cannot be reached:

Name	Relationship	Home Phone	Work Phone	Cell Phone
1)				
2)				
3)				

Please complete the following health questionnaire regarding your child. The information will be reviewed by the school nurse and shared with school personnel as necessary (with permission – see below).

Does your child have any of the following (Please circle yes or no)?			**Comments**
Significant Health History	YES	NO	
Asthma	YES	NO	
ADD/ADHD (circle which)	YES	NO	
Seasonal Allergies	YES	NO	
Non – Life Threatening Allergies (food, insect,)	YES	NO	
Life Threatening Allergies (anaphylaxis)	YES	NO	
Bleeding Disorder	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Eating disorder, anorexia, bulimia, obesity	YES	NO	
Hearing Concerns	YES	NO	
Heart (cardiac) condition	YES	NO	
Kidney/bladder condition	YES	NO	
Mental health concerns(depression, anxiety, fears etc.)	YES	NO	
Seizure Disorder	YES	NO	
Neurological condition (involuntary muscle movement, uncontrollable speech, etc.)	YES	NO	
Speech Delay	YES	NO	
Vision Concerns	YES	NO	
Other Chronic Health Concern not listed above	YES	NO	

Does your child require any of the following (Please circle yes or no)?			**Comments**
Glasses	YES	NO	
Contact Lenses	YES	NO	
Hearing aids	YES	NO	
Prosthesis	YES	NO	
Medication at school	YES	NO	
If yes, please list:			

Does your child require special health care needs? YES NO
If yes, the school nurse will contact you to develop a school based health plan.
If yes to any of the above, please explain: _____

Permission to share above Health Information with school personnel as needed? YES NO
Date: _____ Parent Signature: _____

STAG 4/08