

UNION COUNTY BOARD OF DD

HAROLD LEWIS CENTER

EMERGENCY MEDICAL INFORMATION / AUTHORIZATION 2017-2018

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.

Child's Name _____ Birth Date _____

Address _____

Mother's Name _____ Home Phone _____

Work Phone _____

Cell Phone _____

Father's Name _____ Home Phone _____

Work Phone _____

Cell Phone _____

Name of Relative or Childcare Provider _____

Address _____ City _____

Daytime Phone _____

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments:

Allergies: Please list & describe allergies below. Indicate Mild, Moderate, or Severe
Dietary Restrictions, Food Allergies or Special Diets:
Medications: What medications are given daily? Reason? What medications are giving occasionally? Does your child need medication at school?
<small>*PLEASE SEE NURSE IF MEDICATION IS NEEDED AT SCHOOL</small>
Health Conditions or Diagnoses:

PART I OR II MUST BE COMPLETED (See reverse side)

PART I: TO GRANT CONSENT * These must be filled out completely.

I hereby give consent for the following medical care providers and local hospital to be called:

*Physician _____ Phone _____

Address _____

*Dentist _____ Phone _____

Address _____

Medical Specialist _____ Phone _____
(If applicable)

Address _____

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 above-named doctors, 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian 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 emergency treatment, I wish the school authorities to take the following action:

Parent/Guardian Signature _____ Date _____

PERMISSION TO APPLY SUNSCREEN

I give my permission to the staff of the Harold Lewis Center to apply sunscreen on _____ at appropriate times.

Child's Name

_____ I will send the sunscreen in my child's book bag during warm weather.

_____ I do not wish to have sunscreen applied to my child.

Parent/Guardian Signature

Date