Los Lunas School District

ID Number ___________________

Grade________________________

HEALTH INFORMATION & EMERGENCY AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parents cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS! Please print clearly !!!**

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

Last Name:	First Name:	Middle Initial:	Gender: M F	DOB:
NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:				

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian can not be reached. PLEASE KEEP THESE NUMBERS CURRENT!

Parent/Guardian:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3
Parent/Guardian:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3

	Name	Relationship	Phone #1	Phone#2	Phone #3
1.					
2.					
3.					
4.					
5.					

SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box(s)

☐ **My child has no health conditions including those listed below** ☐ **My child will need to have medication at school.**

☐ **My child has been diagnosed with the health conditions checked below:**

Allergies: ☐ Seasonal	☐ Food (List):	☐ Other Allergy (List):	☐ Has EpiPen prescription
☐ ADD/ADHD	☐Congenital/Genetic	☐ Ear/Nose/Throat	☐ Pulmonary (Other than Asthma)
☐ Asthma Needs Inhaler at School: **Y N**	☐ Eye/Vision Wears glasses/contacts: **Y N**	☐ Diabetes (circle one) Type 1 Type 2	☐ Cardiovascular (List)____________ ☐ High Blood Pressure: **Y N**
☐ Cancer	☐ Dermatologic/Skin	☐ Stomach/GI	☐ Musculoskeletal
Long Term Medications (List):	☐ Eating Disorder	☐ Bladder/GU	☐ Dental/Oral
	☐ Endocrine Other than Diabetes	☐ Hematology/Bleeding Disorders	☐ Psychiatric (List Meds):
☐ Any Other Health Conditions:		☐ Migraines	☐ Seizures

SECTION THREE –CONSENT FOR TREATMENT AND EMERGENCY TRANSPORT

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand Emergency Medical Services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital: (circle one) Presbyterian Lovelace UNMH	

If for any reason I CANNOT BE REACHED, I give permission for appropriate treatment, transport and medical care of my child to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless at least two licensed medical providers concur to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's medical providers regarding medical management of my child and for the providers to release all medical information to the school Nurse. I give permission to share my child's health information with appropriate school personnel when needed to assure the health, safety, and well-being of my child. I give permission for my child to participate in all school health screenings unless I provide the school health office with a separate written notification requesting exclusion from these screenings.

X Parent/Guardian Signature: ____ Date: ____________________________

FOR STAFF USE ONLY: Posted By: ______________________ Date Posted: ________________ Rev 11/15/2018