

STUDENT NAME _____
(Please print) Last First

KNIGHTS FEEDER VOLLEYBALL EMERGENCY MEDICAL AUTHORIZATION FORM

Date of Birth _____ Home Phone _____
School _____ Address _____
School Year _____ Grade _____ City _____ Zip _____

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone _____ Cell _____
Father's Name _____ Daytime Phone _____ Cell _____
Emergency 1. _____ Daytime Phone _____ Cell _____
Contacts: 2. _____ Daytime Phone _____ Cell _____
3. _____ Daytime Phone _____ Cell _____

☐ No medical conditions ☐ No allergies ☐ Medication allergy: _____

Allergic to: _____

☐ Requires treatment with epi-pen/antihistamine-- **Emergency Allergy Plan/Epinephrine Authorization required**

☐ No medication required for allergy treatment-- **Allergy No Medication Form required**

☐ **Asthma**

☐ Requires inhaler/nebulizer at school-- **Asthma Action Plan/inhaled asthma medication authorization required**

☐ No inhaler/nebulizer required at school-- **Asthma/No Medication Plan required**

☐ **Diabetes** ☐ Requires Insulin ☐ Requires oral diabetes medications _____

☐ **Seizure Disorder** **Type:** _____

☐ Requires Emergency rescue medication--

☐ No emergency rescue medication require

☐ **Heart/blood problems:** _____

☐ **Other (Specify)** _____

Medications taken at home: _____

☐ Medications to be given at school: _____

Requires Prescription/Non-Prescription authorization form

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital/Emergency Room Phone _____

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 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 dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian

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:

Signature of Parent/Guardian

Date