Aldo Leopold Charter School
Emergency Medical Authorization Form

Student's Name _____Grade_____Phone_____

Address_____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 contacted. This form will accompany student on all field trips.

Mother's name _____Phone #s Home_____Work_____Cell_____

Father's name _____Phone #s Home_____Work_____Cell_____

Alternative emergency contacts: (Local people to contact if parents cannot be reached; and have your permission to check out your child or make medical decisions.)

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary.

Doctor_____Phone_____

Dentist_____Phone_____

Hostipal_____Phone_____

Student Medical Insurance_____Plan/Group/I.D. Number_____

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transportation and medical care of my child to any appropriate medical care provider, hospital, or medical facility. I authorize ALCS personnel to make necessary decisions and take appropriate actions in emergency situations on behalf of my student. The authorization does not cover major surgery unless one other doctor/dentist concurs 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.

May this student receive over-the–counter medications? Yes or No If yes, list which ones are ok:

_____

I give my child permission for to participate in water activities under adult supervision. YES or NO

I give my child permission to participate in kayaking activities. YES or NO

Signature of Parent/Guardian _____Date_____

Health History

Student Name_____D.O.B._____Grade_____

Health Issues: Check any health issues pertaining to your child.

_____Allergies (list below)

_____Anxiety/panic attacks

_____Arthritis

_____Asthma

_____Birth defects/congenital malformations

_____Cancer

_____Cystic fibrosis

_____Depression

_____Diarrhea or constipation (chronic)

_____Diabetes

_____Dietary Restrictions

_____Eating Disorders

_____Heart Disease or surgery

_____Hepatitis

_____Kidney Disease

_____Seizures/Epilepsy

_____Sickle cell disease

_____Skin rashes (frequent)

_____Stool soiling

_____Throat infections

_____Tics/nervous twitches

_____Urinary tract infections

_____Urinary incontinence

_____Other

Please explain any issue checked above in as much detail as possible:

_____

_____

Vision _____ glasses _____ contacts

Hearing Any loss of hearing? _____ Which ear? _____

Frequent ear infections? _____ Which ear? _____ How often?_____

Describe any serious illness, injury, surgery, hospitalizations

_____

_____

Medications – List name and dosage of any medications being taken this year at home or school

_____

_____

Other Concerns – Please explain below.

Social_____Behavioral_____

Emotional_____