EMERGENCY MEDICAL/DENTAL AUTHORIZATION

Student's Name:_____ Date of Birth:_____ Grade:_____

Address: _____ School: _____ Home phone:_____

PURPOSE: For a safer school environment, parent(s) and guardian(s) authorize the provisions of emergency medical/dental treatment for children who become ill or injured while under school authority when parent(s) or guardian(s) cannot be reached. **Your child may not attend field trips until this form is complete and returned to the school.**

I/We, the parent(s) and guardian(s) of _____, a student in the School District of Beloit schools, do hereby authorize and direct the principal or his/her designee to provide for my child in the event such child shall have an accident, injury, or illness when immediate medical, surgical, or dental care is needed, provided there shall first be a diligent effort to notify me of the situation, and obtain my preferences by calling me at:

_____

Name of Parent/Guardian Home Phone Cell Phone

_____

Name of Parent/Guardian Home Phone Cell Phone

If such efforts to get in touch with me are unsuccessful I/We authorize the principal, or his/her designee, to transport my child to the emergency room of the Beloit Health System or nearest emergency facility, or to call the paramedics, if the principal or his/her designee deems such action warranted. At the hospital, the child shall be given treatment and care by a duly licensed medical professional. I understand that the School District of Beloit will not assume responsibility for medical expenses for my child. I agree to bear such responsibility and pay any such expenses incurred with respect to such a medical emergency.

BELOW CHECK ANY CURRENT HEALTH CONDITION THAT MAY REQUIRE ATTENTION DURING THE SCHOOL DAY OR DURING A SCHOOL SPONSORED ACTIVITY. PLEASE INCLUDE PRESCRIBED, OVER THE COUNTER, AND HERBAL MEDICATIONS CURRENTLY BEING TAKEN. PLEASE LIST ALL THAT APPLY, EVEN IF YOU HAVE LISTED IT ON PAST FORMS.

☐ **ALLERGIES (BE SPECIFIC)**

FOODS _____ **REACTION** _____

BEE STING OR INSECT BITES _____ **REACTION** _____

MEDICINES _____ **REACTION** _____

ENVIRONMENTAL / SEASONAL _____ **REACTION** _____

OTHER (ANIMAL/LATEX) _____ **REACTION** _____

DOES YOUR CHILD REQUIRE AN EPIPEN FOR THEIR ALLERGIC REACTION? ☐ **YES** ☐ **NO**

☐ **ASTHMA:**

MY CHILD USES HIS/HER INHALER: ☐ **DAILY** ☐ **WEEKLY** ☐ **MONTHLY** ☐ **SEASONALLY** ☐ **EXERCISE ONLY**

MY CHILD HAS NOT USED MEDICATION FOR HIS/HER ASTHMA IN THE LAST YEAR: ☐ **YES** ☐ **NO**

☐ **DIABETES: INSULIN DEPENDENT** ☐ **YES** ☐ **NO**

☐ **SEIZURE CONDITION: DATE OF LAST SEIZURE:** _____

☐ **CARDIAC (HEART) CONDITION, MY CHILD HAS:** ☐ **MURMUR** ☐ **HEART DISEASE**

☐ **OTHER HEALTH CONDITIONS (ADHD, AUTISM, BLOOD DISORDER, ETC…), PLEASE LIST** _____

_____

MEDICATIONS CURRENTLY BEING TAKEN: _____

PRIMARY CARE PHYSICIAN / PRACTITIONER for my child: _____

Address: _____ Phone #: _____

PREFERRED DENTIST for my child: _____

Address: _____ Phone #: _____

OPTIONAL: IS YOUR CHILD CURRENTLY ENROLLED IN A HEALTH INSURANCE PLAN (Private, Medicaid, Badgercare, Other): ☐ **YES** ☐ **NO**

Signature of Parent/Legal Guardian: _____ **Date:** _____