



CONFIDENTIAL

Lorain City Schools
EMERGENCY MEDICAL AUTHORIZATION

Please complete this form in **blue or black** ink only.

SCHOOL _____

Rm.# _____ Grade _____

Date _____

Student name _____ D.O.B. _____
Last First Mid

Address _____ Home Phone # _____
Street City Zip Cell # _____

MEDICAL HISTORY

| | YES | NO | | YES | NO |
|-------------------|-------|-------|----------------|-------|-------|
| Diabetes: | _____ | _____ | ADHDs: | _____ | _____ |
| Insulin Dependent | _____ | _____ | Medications | _____ | _____ |
| Oral Medications | _____ | _____ | | | |
| Epilepsy: | _____ | _____ | Vision: | _____ | _____ |
| Medication | _____ | _____ | Glasses | _____ | _____ |
| Hearing: | _____ | _____ | Allergies: | _____ | _____ |
| Hearing Aides | _____ | _____ | Medications | _____ | _____ |
| | | | _____ | _____ | _____ |
| Heart Disease: | _____ | _____ | Environmental: | _____ | _____ |
| | | | _____ | _____ | _____ |
| Orthopedics: | _____ | _____ | Bee Sting: | _____ | _____ |
| Assisted Aides | _____ | _____ | _____ | _____ | _____ |
| Asthma: | _____ | _____ | Food: | _____ | _____ |
| Inhaler/Nebulizer | _____ | _____ | _____ | _____ | _____ |
| ADD: | _____ | _____ | | | |
| Medication | _____ | _____ | | | |

If any of the above are checked, please explain: _____

MEDICATION: Name / Type and Use _____

If your child is allergic to bees, what symptoms does he/she have after being stung and what action needs to be done?

Is medication prescribed? _____

Student name _____
Last First Mid

Statement regarding consent when contact of parent(s) is unsuccessful: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctor/dentist, or in the event the designated preferred practitioner is not available, by another licensed physician/dentist and (2) the transfer of the child to any hospital reasonable accessible.

PART I - TO GRANT AUTHORIZATION FOR RELEASE OF STUDENT

List the names of persons to whom your child may be released. Include the name and address of parents and three people **other than parents** that may assume responsibility of your child.

Your child will not be released to any person other than those listed on this form.

Parent / Legal Guardian _____ Address _____ Phone _____

Work Phone _____

Parent _____ Address _____ Phone _____

Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

Contact Name _____ Address _____ Phone _____

Relationship _____ Cell Number _____ Work Phone _____

AUTHORIZATION FOR EMERGENCY CARE

I hereby give consent for the following medical care providers and local hospitals to be called.

Doctor _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

Hospital _____ Address _____ Phone _____

Parent / Legal Guardian Signature