FIRST NAME:_____ LAST NAME:_____

SAMS ACADEMY HEALTH AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's 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!

Last Name:	First Name:	Middle Initial:	DOB:

NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

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 cannot be reached.

PLEASE KEEP THESE NUMBERS CURRENT!

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

	Emergency Contact List	Relationship	Phone #1	Phone #2
1				
2				
3				

SECTION TWO - STUDENT HEALTH HISTORY - Please circle and give details where necessary

My child has no health conditions including those listed below _____ initial here

Allergies:	Seasonal(list)		Has Epipen prescription Y N
Food(List)		Other Allergy(list)	
ADD/ADHD	Congenital/Genetic	Ear/Nose/Throat	Pumonary (Other than Asthma)
Diabetes (circle one)	Musculoskeletal	Asthma	Cardiovascular (list)
Type 1 Type 2	Eye/Vision	Needs Inhaler at School Y N	High Blood Pressure Y N
Cancer	Wears glasses/Contacts Y N	Stomach/GI	Endocrine (Other than Diabetes)
Eating Disorder	Dermoatologic/Skin	Dental/Oral	Hematology/ Bleeding Disorders
Bladder/GU	Migraines	Psychiatric : (List Meds)	
Long Term Medications List:			
Any additional Information about your child we should know:			

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Subcribers Name:	ID#

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:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This 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. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature_____ Date: _____

FOR OFFICE USE ONLY

STUDENT NAME: ______________________________ GRADE: ______/TEACHER____________________

☐ **IHP in Health Folder** ☐ **Epi Pen at school** ☐ **Diastat at school** ☐ **Glucagon at school** ☐ **Inhaler at school** ☐ **Meds at school**

Date	Time In	Complaint	Time Out	Disp.	Initials

Signature/Initials: ____________________ ____________________ ____________________