



Hamilton Community Schools
 903 South Wayne Street
 Hamilton, IN 46742
 Phone: 260.488.2101 Fax: 260.488.3149

Emergency Medical Authorization/Permit

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnosis, and treatment. Including surgical intervention, if necessary, on behalf of my minor child listed below and do all other necessary things as I might or could do to provide for the child's health and safety; if I were present.

*This authorization is valid for the current school year or until such time as I withdraw-the authorization.

Authorized: _____ Date: _____
 (Custodial Parent/ Guardian)

Student's Name: _____ Date of Birth: _____

Home Address: _____ Grade: _____ Teacher: _____

Custodial Parent/Guardian: _____ Primary Phone: _____

Parent/Guardian 1 Name: _____ Primary Phone: _____

Parent/Guardian 1 Work: _____ Work Phone: _____

Parent/Guardian 2 Name: _____ Primary Phone: _____

Parent/Guardian 2 Work: _____ Work Phone: _____

- Since the care and treatment of the student is the primary responsibility of the parent, every effort will be made to contact the parent's first. Please list Parent Substitutes who can be contacted regarding student's care in the event a parent cannot be reached. Please Note: Only those listed below will be permitted to pick up your child in case of an illness or emergency.

Sub's Name: _____ Relationship: _____ Phone: _____

Sub's Name: _____ Relationship: _____ Phone: _____

Sub's Name: _____ Relationship: _____ Phone: _____

- List anyone who is NOT PERMITTED to pick up your child from school:

Name: _____

Name: _____

Important Medical Information:

Hospital Preferred: _____

Doctor Preferred: _____ Telephone: _____

Dentist Preferred: _____ Telephone: _____

Insurance Company: _____ I.D Number _____

IF THE SCHOOL REPRESENTATIVES ARE UNABLE TO CONTACT PARENTS IN THE EVENT OF AN EMERGENCY, THE SCHOOL WILL HAVE YOUR CHILD TRANSPORTED BY AMBULANCE.

Parent/Guardian Signature: _____ Date: _____



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2020-2021 School Year

Annual Health Update

Student Name: _____ Grade: ____ Teacher: _____
 Parent/Guardian: _____ Telephone: _____
 Family Doctor: _____ Telephone: _____

*Please check-all health conditions below that affect-your-child:

- | | |
|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Malignancy/Cancer Type: _____ |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures Type: _____ |
| <input type="checkbox"/> Bee Sting / Insect Allergy | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Food Allergy ... | <input type="checkbox"/> Hemophilia/ Bleeding Disorder |
| <input type="checkbox"/> Diabetes | Other: _____ |
| <input type="checkbox"/> Cystic Fibrosis | _____ |
| <input type="checkbox"/> Gastrointestinal Disorder | _____ |
| <input type="checkbox"/> Hearing Loss | List any drug allergies: _____ |
| <input type="checkbox"/> Visual Impairment | _____ |
| <input type="checkbox"/> Heart Condition | _____ |
| <input type="checkbox"/> Kidney Disorder | _____ |

Explain any treatments and considerations the school nurse and necessary staff need to be aware of regarding your child's diagnosis:

List all medications including administration time and dosage:

Past surgical history:

** By signing this form you agree the above information will be shared only with necessary staff and emergency care personnel directly involved in the care, safety, and well-being of your child.**

 Parent/Guardian Signature

 Date