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

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

Name: _____
Name: _____

Important Medical Information:

Hospital Preferred: St.Joe
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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23-24 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:

_____ADD/ADHD
_____Seasonal Allergies
_____Asthma
_____Bee Sting / Insect Allergy
_____Food Allergy
_____Diabetes
_____Cystic Fibrosis
_____Gastrointestinal Disorder
_____Hearing Loss
_____Visual Impairment
_____Heart Condition
_____Kidney Disorder

_____Malignancy/Cancer Type:_____
_____Neurological Disorder
_____Seizures Type:_____
_____Sickle Cell Anemia
_____Hemophilia/ Bleeding Disorder
Other: _____

List any drug allergies: _____

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