2023-2024 Health Information and Emergency Treatment Permission Statement

Student's Name _____ School _____ Grade _____

Last Name / First Name / Full Middle Name

Birth Date (Month/Day/Year)		Sex: ☐Male ☐Female
Birth City	Birth County	Birth State

PARENT INFORMATION	Primary Guardian ☐Mother ☐Father ☐Other Guardian ☐Stepfather ☐ Stepmother ☐ Grandparent	Secondary Guardian ☐Mother ☐Father ☐Other Guardian ☐Stepfather ☐ Stepmother ☐ Grandparent
Name: First / Last		
Street or 911 Rural Address		
Mailing Address (if different)		
City/State/Zip		
Home Phone Number		
Cell Phone Number		
Work Place & Phone Number		
E-mail Address		

It is your responsibility to make arrangements for proper care in case your child should have an accident or become ill while attending school. Should you be away from home, the following will help you and your child in receiving proper care and notification.

1) Designate a neighbor or relative to care for your child in their home until you can be reached.
2) Inform designated persons that you have used their names and advise them of their responsibilities.
3) If any information should change during the school year please notify the Building Principal or Dean of Students.

IF MY CHILD BECOMES ILL AND I CANNOT BE REACHED, PLEASE NOTIFY:

	Name	Relationship	Daytime Phone	Cell Phone
First Contact				
Second Contact				

HEALTH INFORMATION (If medication is to be given at school, please complete & attach required consent form.)

✓	Medical Condition (Check all that apply.)	Give Details of Condition – Treatment/Medication/Dosage Instructions
☐	ADD/ADHD	☐ Yes Please specify
☐	Allergies–Food/Medicine/Insects	Epi-Pen? ☐Yes Please specify
☐	Asthma	Inhaler? ☐Yes Please specify
☐	Diabetes	☐ Yes Please specify
☐	Ear Infections/Hearing Problems	Hearing Device? ☐Yes Last Exam Date:
☐	Heart Condition	☐ Yes Please specify
☐	Pneumonia	☐ Yes Please specify
☐	Rheumatic Fever	☐ Yes Please specify
☐	Scarlet Fever	☐ Yes Please specify
☐	Seizure Disorder	☐ Yes Please specify
☐	Tonsillitis	☐ Yes Please specify
☐	Vision Problems	Glasses/Contact Lenses? ☐Yes Last Exam Date:
☐	Other Serious Illness/Injury (Describe)	☐ Yes Please specify
☐	Check here if more information is provided on Page 2.	

Note: Administration of **any** prescribed or over the counter (OTC) medicine during the school day **MUST** have a Medication Administration form completed by a physician.

(OVER)

The welfare of your child is the first consideration of the school authorities. In case of a serious medical emergency or illness an ambulance will be called. The parent or guardian will be informed and the authorized physician will be notified. The school nurse will follow up on treatment received on a case by case basis. In case of a less serious emergency, the school will contact the parent or guardian at home or at work.

I hereby give permission to the proper authorities at Taylorville Community Unit School District #3 to seek the appropriate medical assistance for my child in the event of any injury. I likewise understand that Taylorville School District is not liable for the payment of the medical costs in the event of injury sustained.

_____ _____

Parent/Guardian Signature Date

PARENTAL CONSENT FORM FOR EMERGENCY TREATMENT

I, _____ parent [or legal guardian] of _____, have enrolled my child in_____ School and hereby authorize Dr. _____, my child's physician, or any physician in his or her group practice, on my behalf to administer emergency medical assistance to my child during school or a school-sponsored activity. In the event my child's physician or any physician in his or her group practice is not available, or contact with my child's physician is not practical under the circumstances, I hereby authorize Taylorville Community Unit School District #3, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized school personnel believe such emergency medical assistance is necessary to protect the health, safety, and welfare of my child.

I further waive any claims against Taylorville Community Unit School District #3, the members of the Board of Education, its employees and agents arising out of the provision of or arrangement for emergency medical assistance to my child and agree to hold harmless and indemnify Taylorville Community Unit School District #3, the members of its Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the provision of or arrangement for emergency medical treatment.

Parent/Guardian Signature _____

Date _____

Doctor's Name:_____ Doctor's Phone Number_____

Office Address/City _____

Dentist's Name:_____ Dentist's Phone Number _____

Office Address/City _____

Health Insurance Carrier: _____ Policy Number_____

ADDITIONAL MEDICAL INFORMATION (Attach an additional sheet if more space is needed.)