



**LOVING MUNICIPAL SCHOOLS**  
**EMERGENCY MEDICAL AUTHORIZATION FORM**



**PURPOSE:** To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to school. The original form and any copies thereof may used to identify the medical options of the undersigned parent.

School District	School Building	Home Room Teacher	Grade
Student's Full Name _____			
Last	First	Middle	SSN#
Student's Address _____			
Street/Road	P.O. Box/ Appt #	City	Zip Code
Student's Birth Date _____		Telephone _____	Age _____
Student's Place of Birth _____		Ethnicity _____	Sex: Male _____ Female _____
Mother's Name _____		Daytime Phone _____	
Father's Name _____		Daytime Phone _____	
Guardian/Child Care Provider _____		Daytime Phone _____	
Guardian/Child Care Provider's Address _____			
Street/ Road	P.O. Box/Apt #	City	Zip

Does the student ride the bus? Yes or No                      If yes, please indicate the bus number. \_\_\_\_\_

**ALERNATE EMERGENCY CONTACTS (Local people to contact if parents cannot be reached.)**

Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____

**TO GRANT CONSENT**

In case of medical emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary.

Doctor _____	Phone _____
Dentist _____	Phone _____
Nurse Practitioner/ Physical Assistant _____	Phone _____
Hospital _____	Phone _____

**If for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concur or the needed.**

**Nothing in this section shall be constructed to impose liability on any school official or school employee who, in good faith, attempt to comply with this section. It is understood that I will be financially responsible for all emergency care.**

Signature of Parent/ Guardian \_\_\_\_\_ Date \_\_\_\_\_

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN  
SHOULD BE ALERTED

Please indicate if the student has had or is currently under treatment for any of the following conditions:

Give year or age when problem occurred.

_____ ASTHMA	_____ MENINGITIS
_____ DIABETES	_____ MIGRAINE HEADACHE
_____ EAR/ HEARING PROBLEM: (type)_____	_____ MUSCULAR WEAKNESS OR PARALYSIS
_____ EMOTIONAL PROBLEMS: (type) _____	_____ BLEEDING DISORDER: (type) _____
_____ SEIZURES	_____ HIGH BLOOD PRESSURE
_____ HEART PROBLEMS: (type)_____	_____ INFECTIOUS DISEASE(type) _____
_____ HEPATITIS: (type)_____	_____ TETANUS SHOT: (date) _____
_____ OTHER: _____	_____ HEPATITIS B SHOT: (date) _____
_____ ALLERGIES?	

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\_\_\_\_\_ REACTION TO MEDICINE OR INJECTIONS? \_\_\_\_\_

\_\_\_\_\_ HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY, OR ACCIDENTS? \_\_\_\_\_

\_\_\_\_\_ USE OF CONTACT LENS      YES \_\_\_\_\_      NO \_\_\_\_\_

\_\_\_\_\_ LONG TERM MEDICATIONS? \_\_\_\_\_

\_\_\_\_\_ HAVE YOU EVER BEEN INFORMED OF THE NEED TO BE ON ANTIBIOTIC THERAPY PRIOR TO DENTAL  
TREATMENT?      YES \_\_\_\_\_      NO \_\_\_\_\_

IF YES, IDENTIFY REQUIRED THERAPY \_\_\_\_\_

\_\_\_\_\_ PLEASE ADD ANY PROBLEMS NOT LISTED \_\_\_\_\_

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Is student covered by health insurance?      YES \_\_\_\_\_      NO \_\_\_\_\_

Name of Insurance Company (Primary) \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ ID Number or Group Number \_\_\_\_\_

Does Medicaid cover student?      YES \_\_\_\_\_      NO \_\_\_\_\_

If yes, please indicate Medicaid I.D. Number \_\_\_\_\_

Does Children's Medical Service cover student?      YES \_\_\_\_\_      NO \_\_\_\_\_