

Spencerville Local School District

Student Name _____

ELEMENTARY – BRING ON FIRST DAY!

Address _____

(K-4) Homeroom Teacher _____

Home Phone _____

PURPOSE – TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL/INJURED WHILE UNDER SCHOOL AUTHORITY WHEN PARENTS OR GUARDIANS CANNOT BE REACHED. PLEASE LIST AT LEAST 2 DIFFERENT CONTACT NUMBERS BELOW.

RESIDENTIAL PARENT OR GUARDIAN

Call **FIRST (1)** _____

Call **SECOND (2)** _____

Daytime Phone _____

Daytime Phone _____

Cellular Phone _____

Cellular Phone _____

Call **THIRD (3)** _____

Call **FOURTH (4)** _____

Daytime Phone _____

Daytime Phone _____

Cellular Phone _____

Cellular Phone _____

PART I OR II MUST BE COMPLETED (PART I: TO GRANT CONSENT)

PART I

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____

Phone _____

Dentist _____

Phone _____

Medical Specialist _____

Phone _____

Local Hospital _____

Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent to (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and, (2) the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date _____

Signature of Parent/Guardian _____

Address _____

PART II: REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child in the event of illness or injury requiring emergency treatment. I wish school authorities to take the following action: _____

Date _____

Signature of Parent/Guardian _____

Address _____

SPENCERVILLE LOCAL SCHOOL DISTRICT

Elementary School Health Record

Student Name _____ M F DOB: _____
 (Last) (First) (MI)

Grade K 1 2 3 4 Name of Physician _____

Parent/Guardian Name(s): _____

Has your child ever had or has now any of the following? Please check at the right of each item:

Condition	Yes	No	Year	Condition	Yes	No	Year
Asthma				High Blood Pressure			
Attention Deficit Disorder (ADD or ADHD)				Migraine Headaches			
Bleeding Disorder				Scoliosis in Family			
Bone or Joint Disorder				Severe Insect Bite or Sting Sensitivity			
Chickenpox				Severe Life Threatening Allergies List:			
Diabetes				Speech Problems			
Epilepsy or Seizures				Tuberculosis (TB)			
Food or Other Allergies (Non-Life Threatening) List:				Tumor, Growth, or Cancer			
Frequent Ear Infections				Wears Glasses or Contacts (which one?)			
Hearing Loss				Wears Prosthesis			
Heart Condition				Other:			

List any drug allergies that your child has: _____

List any operations your child has had and when: _____

List any prescribed medication your child is currently taking: _____

Will your child be taking any medication during school hours? No Yes, required forms in clinic or office

Please list **any additional** information concerning your child's health or medical condition of which the school staff should be aware: _____

Thank you for your cooperation!