



EMERGENCY INFORMATION & MEDICAL AUTHORIZATION
Grace Community School

Student Name _____ Birth Date ____ / ____ / ____ Home Phone _____

Student Address _____

Student Lives With: _____ Parent's E-Mail _____

Mother's Name _____ Daytime Phone (____) _____ Cell (____) _____

Father's Name _____ Daytime Phone (____) _____ Cell (____) _____

Other Name _____ Daytime Phone (____) _____ Cell (____) _____

Local Contact when parents or guardians cannot be reached:

Name _____ Relationship _____ Daytime Phone (____) _____

Name _____ Relationship _____ Daytime Phone (____) _____

STUDENT'S HEALTH CONCERNS

____ ASTHMA ____ ALLERGIES ____ DIABETES ____ ECZEMA ____ HEADACHES (frequently) ____ HEART DISEASE
____ KIDNEY DISEASE ____ SEIZURES/EPILEPSY ____ VISION ISSUES ____ HEARING ISSUES ____ OTHER _____

Please comment on any of the above: _____

Medications Given: _____ Daily/Frequently? _____

_____ Daily/Frequently? _____

Any Prior Severe Injuries or Illnesses:

____ Age _____ Illness/Injury _____ Hospitalized

____ Age _____ Illness/Injury _____ Hospitalized

Do you have any concerns about this child's health, development, behavior, family or home life that you would like to share with the school? If yes, please explain. _____

CONSENT

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

Doctor: _____ Dentist: _____ Specialist: _____

Phone: _____ Phone: _____ Phone: _____

Hospital: _____

In the event reasonable attempts to contact me have failed, I hereby give my consent for (1) 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 reasonably accessible.

Parent Signature _____ Date _____

REFUSAL OF CONSENT

I DO NOT GIVE CONSENT for emergency medical treatment of my child in the event of illness or injury requiring emergency treatment, I wish the school to take the following actions: _____

Parent Signature _____ Date _____

Completed by: _____ Relationship to Child: _____