St. John's Lutheran School

Emergency Medical Authorization

First Name: ____________________ MI: ______ Last Name: ______________________

Grade: ____________________ Date of Birth: ___________ Phone Number: ____________________

Address: ____________________________________ City: ____________State: ____Zip Code: _______

In case of emergency contact: **(LIST AREA CODE IF DIFFERENT THAN 937)**

Name	Home	Cell#	Employer	Work #

Emergency Medical Authorization

******You MUST complete PART I or PART II ******

Part I—TO GRANT CONSENT

I hereby give consent for the following medical care providers or hospitals to be called:

Doctor: ____ Phone: ____________________________

Dentist: ____ Phone: ____________________________

Allergies, Medical Conditions OR Medications: YES If YES, explain in detail on back of this form

In the event reasonable attempt to contact me have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practioner is not available, by another licensed physician or dentist and
2. The transfer of me to any hospital reasonably accessible.

Date: _____________ Signature : ______________________________________

Part II—REFUSAL TO CONSENT NO

I do NOT give my consent for the emergency medical treatment of me. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

Date: _____________ Signature : ______________________________________

PLEASE TURN FORM OVER TO FILL OUT THE REQUIRED HEALTH INFORMATION

St. John's Lutheran School

Emergency Medical Health Information

Name: ___________________________________ Date: _______________

I have the following serious or chronic health condition

_____ Asthma-requiring medication * or EMERGENCY treatment

_____ Bee Sting Allergy that requires medications * EMERGENCY treatment

_____ Severe allergy that requires medication * or EMERGENCT treatment

_____ Activity limitation/restriction

_____ ADD or ADHD (circle)

_____ Diabetes *

_____ Hearing Disorder

_____ Vision Disorder

_____ Seizure Disorder

_____ Heart Condition

_____ Urniary Tract Disorder

_____ Muscular/Skeletal Disorder

_____ Respiratory Illness (other than Asthma)

_____ Other Serious or Chronic Conditions

Explain: ____

If any condition above with * denoted, please fill out the required medication and/or physician authorization forms located on the website: www.sjsmarysville.org

Do you have any condition that could be life threatening? CIRCLE ONE: YES OR NO
If YES, please explain:

____

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