ROSWELL SCHOOLS HEALTH INFORMATION & EMERGENCY AUTHORIZATION FORM Gr_____Teacher_____

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: M F	DOB:

NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian can not be reached. PLEASE KEEP THESE NUMBERS CURRENT!

Parent/Guardian:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3
Parent/Guardian:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3

	Name	Relationship	Phone #1	Phone#2	Phone #3
1.					
2.					
3.					
4.					

Siblings in RISD Schools

	Name	School/Daycare	Grade	DOB
1.				
2.				
3.				

SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box

☐ **My child has no health conditions including those listed below**

Allergies: ☐ Seasonal ☐ Food (List):		☐ Other Allergy (List):	☐ Has EpiPen prescription
☐ ADD/ADHD	☐ Congenital/Genetic	☐ Ear/Nose/Throat	☐ Pulmonary (Other than Asthma)
☐ Asthma Needs Inhaler at School: **Y N**	☐ Eye/Vision Wears glasses/contacts: **Y N**	☐ Diabetes (circle one) Type 1 Type 2	☐ Cardiovascular (List)_____ High Blood Pressure: **Y N**
☐ Cancer	☐ Dermatologic/Skin	☐ Stomach/GI	☐ Musculoskeletal
Long Term Medications (List):	☐ Eating Disorder	☐ Bladder/GU	☐ Dental/Oral
	☐ Endocrine Other than Diabetes	☐ Hematology/Bleeding Disorders	☐ Psychiatric (List Meds):
☐ Any Other Health Conditions:		☐ Migraines	

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Name of insured parent/guardian:	ID#

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I give permission for appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless at least two licensed medical providers concur to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I give permission to share my child's health information with appropriate school personnel when needed to assure the health, safety, and well-being of my child. I give permission for my child to participate in all school health screenings unless I provide the school health office with a separate written notification requesting exclusion from these screenings. I give permission to administer basic first aid to my child following school protocol including, but not limited, to topical antibiotic ointment, cough drops, eye wash, etc. unless contraindicated.

Parent/Guardian Signature: _____ Date: _____