

st. angela merici catholic church ~ yosa ~ 2009/2010

Medical Questionnaire and Emergency Medical Authorization

Student Information...

Please PRINT legibly.

Last Name: _____ Date: _____
 First Name: _____ School: _____
 Address: _____ Grade: _____
 City: _____ Zip: _____ Date of Birth: _____
 Home Phone: _____ Cell Phone: _____ Adult T-Shirt Size: _____

STUDENT LIVES WITH: Mother & Father Mother & Stepfather Father & Stepmother
 Father Only Mother Only Guardians

Mother's Full Name: _____ Cell Phone: _____
 Mother's Occupation: _____ Work Phone: _____

Father's Full Name: _____ Cell Phone: _____
 Father's Occupation: _____ Work Phone: _____

Additional Emerg. Contact: _____ BEST Phone Number: _____
 Address: _____ Relation to student: _____

STUDENT MEDICAL HISTORY

Has this student been diagnosed with any of the following conditions? If so, please check whether the condition is current or past history and if medication is currently being taken.

<u>Condition</u>	<u>Current</u>	<u>Past History</u>	<u>Takes Medication</u>	<u>Notes</u>
Allergies	_____	_____	_____	
Asthma	_____	_____	_____	
Bee stings	_____	_____	_____	
Diabetes	_____	_____	_____	
Heart Condition	_____	_____	_____	
Migraines	_____	_____	_____	
Seizures	_____	_____	_____	
Ulcers	_____	_____	_____	

Please explain any condition checked above...

Any condition not listed above (list and explain)...

Food / Dietary Allergies or special needs (list and explain)...

MEDICATIONS

List medications this student is presently taking, dosage, frequency, and medical condition.

Medication _____ Dosage _____ Frequency _____ Condition _____

Medication _____ Dosage _____ Frequency _____ Condition _____

Medication _____ Dosage _____ Frequency _____ Condition _____

I give permission for the youth ministry staff/volunteers to administer the following otc medications in proper dosages...

- Acetaminophen-Tylenol Ibuprofen-Advil Benadryl

Please list and explain any past or present serious illness or hospitalization that we should be aware of.

Please explain any additional health problems, limitations, or special conditions that we should be aware of for emergency treatment of this student.

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact ME at _____ (phone number) OR _____ (alternate phone number) OR _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), 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 _____ (preferred hospital) or any hospital reasonably accessible.

Health Insurance Carrier: _____

Policy #: _____

Name of Policy Holder: _____

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. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date

Signature of Parent or Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 the school authorities to take no action or to:

Date

Signature of Parent or Guardian