3K/4K EMERGENCY MEDICAL FORM – 2016-2017

Student Name____Grade: ________Age: ______________

AUTHORIZATION OF MEDICAL TREATMENT: In the event or an illness or accident, I hereby give permission to a representative of the Spartanburg Day School to act for me in my behalf as the parent or other person having the legal authority to act for the student named above in the securing of medical, surgical, and/or dental treatment. In the event of an emergency, I hereby give permission to the physician selected by Spartanburg Day School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student name. I certify that I am the parent and have the legal ability to sign these authorizations on behalf of the student named above. I consent to the release of information to Spartanburg Day School and to the insurance company. **I understand that every effort will be made to contact me prior to treatment.**

____ *(Signature of Legal Guardian)* _____________________ *(Date)*

PERTINENT INFORMATION: As the parent or legal guardian of the student listed above, I give my permission for the nurse to divulge pertinent information to selected persons in charge of student care regarding any health concerns pertaining to my child.

____ *(Signature of Legal Guardian)* _____________________ *(Date)*

PLEASE provide further information. (Check if the condition applies to the student)

____ Seizures? Epilepsy?

- Type: Grand mal ___ Focal ___ Petite mal ___ Febrile ___ Occurance: once ___ occasional ___ frequent ___
- Treatment: Controlled with medication ___ Medicated only when needed ___

Medication ____

____ Concussion? ______ Date: ___________________________________

____ Fainting? Specify: ____

____ Frequent headaches? Migraines? (*Circle*) suggested treatment ____

____ Asthma? Specify triggers for attacks ____

- Does student carry a rescue inhaler? ___ Does student use a nebulizer? ___

____ Gastro-intestinal or urinary conditions? Specify: ____

Allergies:

___ Food Allergy? To: ____________________________ Reaction: ____

To: ____________________________ Reaction: ____

PLEASE SEE *Food Allergy letter and Treatment Form* included in Health Forms

___ Hay fever (seasonal or environmental) Specify allergen: ____

- Treatment: ____

___ Animal (bee, cat, horse, feathers, dander) Specify:____

___ Medicinal (penicillin, sulfa) Specify: ____

Does your child carry an EpiPen? ______ *(yes or no)*

Please list daily medications (dosage and time of day) that is administered at home:

Medication: ______________________________ Dosage: ___________________ Time: _____________________________

Medication: ______________________________ Dosage: ___________________ Time: _____________________________

Medication: ______________________________ Dosage: ___________________ Time: _____________________________

Medication: ______________________________ Dosage: ___________________ Time: _____________________________

Please provide any other pertinent health information concerning your child that the nurse needs to be made aware.

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