Warren Consolidated Schools

Medical Treatment Authorization

Name:_______________________________ Birthdate:_________Home Telephone:_________________

Parent (Guardian):______________________________ Address:___________________________________

Father's Phone (Work):_______________________ Mother's Phone (Work):______________________

Person to Notify if Parent Cannot Be Reached - Name:____

Address:_____________________________ Phone:____________________ Relation:_______________

PURPOSE OF THIS CARD: To enable parents or guardians to authorize the provision of emergency treatment for minors who become ill or injured while under school authority when parents or guardians cannot be reached. In the event of an emergency requiring medical attention, I hereby grant my permission to the team physician, trainer or coach to administer first aid to my son/daughter____ Yes:_____ No:_____

In the event of an emergency requiring further medical attention, I hereby grant my permission to ______________________(family doctor) at ____________________(preferred hospital) or (if not possible) to attending physician at the hospital designated by the school staff to attend to my son/daughter____________________________. Yes:_____ No:_____

I expect every effort will be made to contact me in order to receive my specific authorization before any major medical treatment or hospitalization is undertaken.

Date:________________ Signature:____

HEALTH HISTORY

Family Doctor:__________________________Phone:___________________Hospital:____________________

Insurance Company:_______________________ Insurance Contract Number:______________________________

Date of Last Physical:______________________ Date of Last Tetanus Shot:_______________________________

Medical History:	YES	NO		
Heart Condition:	____	____	If So Explain:	______________________________
Epilepsy:	____	____		______________________________
Diabetes:	____	____	If So Please State:	______________________________
Asthma:	____	____	If So Please State:	______________________________
Other Condition:	____	____	If So Please State:	______________________________
Wear Contacts or Glasses:	____	____	If So Please Indicate Which:	______________________
Allergic To Any Medication:	____	____	If So Please List:	______________________________

PLEASE FILL CARD OUT COMPLETE AND SIGN IT. PLEASE NOTIFY THE SCHOOL IF ANY OF THE INFORMATION (Above or on the other side) CHANGES DURING THE SCHOOL YEAR.