

**CHIMACUM SCHOOL DISTRICT
MEDICAL EMERGENCY AUTHORIZATION FORM**

Name		Date of Birth
Address	City	Grade
As parent or legal guardian, I authorize a qualified physician to examine the above-named student; and in the event of injury, to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he/she deems necessary to insure proper care of any injury. Transportation, if deemed necessary, will be arranged by school personnel or emergency personnel. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment or transportation.		
Name of Parent/Guardian		
Home Phone		Cell Phone
Emergency Contact		
Home Phone		Cell Phone
Physician's Name		
Phone		Insurance Company and Policy Number
Dentist's Name		Phone

MEDICAL HISTORY

Are you allergic to any medication? Please list:	YES	NO
Do you have any chronic or recurrent illnesses? Please list:	YES	NO
Have you ever been hospitalized? Dates/reason:	YES	NO
Have you ever required an operation? Dates/reason:	YES	NO
Have you ever had a concussion? Dates/reason:	YES	NO
Have you had a tetanus shot within the last five (5) years? Date:	YES	NO
Do you wear glasses or contact lenses? Which one?	YES	NO
Do you wear any dental appliance such as a bridge, plate or braces? List:	YES	NO
Have you ever had asthma or breathing difficulties?	YES	NO
Do you have any organs missing other than tonsils or appendix? (eye, kidney, etc.)	YES	NO
Are you allergic to bee stings or other insect bites? If yes, attach additional information.	YES	NO
Are you currently taking ANY medications? (Please list: include vitamins, aspirin, etc.)	YES	NO
Do you have a health care plan on file in the school office? If yes, please attach additional information.	YES	NO

Parent/Guardian Signature

Date