MEDICAL QUESTIONNAIRE AND EMERGENCY MEDICAL AUTHORIZATION

FAMILY/GUARDIAN MUST COMPLETE THIS FORM YEARLY (both sides)

Must be returned by March 15, 2024

Date: _____ Grade Entering: _____ Date of Birth: _____

Student's Last Name: _____ First Name: _____

Students Address: _____

City: _____ Zip Code: _____

Home Phone: _____

Mother: _____ Daytime Phone: _____

Father: _____ Daytime Phone: _____

Emergency Contact (if parent/guardian is unavailable): _____

Address: _____ Daytime Phone: _____

Student lives with: _____

MEDICAL HISTORY

Please check off the following conditions this student has been diagnosed with:

_____ Allergies: Food: _____ Medication: _____ Bee: _____ Seasonal: _____

_____ Asthma: Inhaler? YES _____ *(see below)* NO _____

Student will carry inhaler at school _____ Student will not carry inhaler at school _____

_____ Diabetes: _____ **(Diabetes Care Plan is required)**

_____ Seizures: _____ **(Seizures Care Plan is required)**

_____ Heart Condition: _____

_____ Gastrointestinal: _____

_____ Migraines: _____ (A physician statement is recommended)

_____ Scoliosis: _____

_____ Vision/Hearing Impairment: _____

_____ Other: _____

Additional space to explain any conditions checked above: _____

Please explain any additional health problems, limitations or special medical concerns that the school should be aware of: _____

MEDICATIONS

List medications this student is currently taking, dose, frequency and medical condition.

Medication: _____ Dose: _____ Frequency: _____ Condition: _____

Medication: _____ Dose: _____ Frequency: _____ Condition: _____

Medication: _____ Dose: _____ Frequency: _____ Condition: _____

Will this student be taking medication at school? YES _____ NO _____

NOTE: All students taking prescription or over-the-counter medication at school **MUST** have on file a Medication Administration Form. Forms are available on the Padua Franciscan High School Website. If needed, please contact the school clinic for further instruction.

Medical information shared with the school may be shared with school officials who have a legitimate educational interest.

PART I OR PART II MUST BE COMPLETED

EMERGENCY MEDICAL AUTHORIZATION

PART I (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____ Tel: _____

Dentist: _____ Tel: _____

Medical Specialist: _____ Tel: _____

Local Hospital: _____ Tel: _____

Dentist: _____

In the event reasonable attempts to contact me at _____ (tel #) or_____ (other parent) at _____ (tel #) have been unsuccessful, I hereby give my consent for: (l) the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) at _____ (tel #), 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.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concur-ring in the necessity for such surgery, are obtained before the surgery is performed.

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/Guardian:

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (REFUSAL OF 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/Guardian: