2018 - 19 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

TO WHOM IT MAY CONCERN:

I_____(the natural parent or legal guardian) hereby give permission that my
(Print Legal Guardian's Name)

child, _____
(Please Print Child's First Child's Middle Child's Last)

may be given emergency treatment to include first aid and CPR by a qualified emergency medical or first aid caregiver. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Name:_____ _____ _____
Parent/Guardian Signature Relationship to child Date

Witness:_____ _____
Signature Date

Emergency Phone Numbers:

Name/Relationship	Phone Number	Cell Phone
Name/Relationship	Phone Number	Cell Phone
Name/Relationship	Phone Number	Cell Phone

Student Address:

_____
House Number and Street Address

_____
City *State* *Country* *Postal Code*

Student's Information:

Student's Date of Birth: _____

Insurance Company: _____

Policy/Membership #:_____ Group #:_____

Policy Holder Name: _____

Allergies and/or Important Health Information: _____

_____

_____

_____

_____

This form must be completed every school year.

2018-19 HEALTH INFORMATION

STUDENT NAME:_____

Please check any of the following symptoms that have been noted:

☐Frequent sore throats ☐Tires easily ☐Frequent earaches ☐Frequent stomach aches

☐Frequent headaches ☐Poor appetite ☐Frequent nosebleeds ☐Shortness of breath

☐Fainting spells ☐Pain in legs or joints ☐Other: _____

Diseases: *Please check any of the following that the student has or had.*

☐4 or more colds a year ☐Measles ☐Poliomyelitis ☐Tonsillitis

☐Pneumonia ☐Ear Infections ☐Chicken Pox ☐Diabetes

☐Mumps ☐Eczema ☐Heart Disease ☐Asthma/Hay Fever

☐Hernia (rupture) ☐Other: _____

Please explain: List any operation, injuries or deformities:

_____

_____

Physical Date: _____ Physician: _____

Has your child ever been around anyone known to have Tuberculosis?

_____

Are there any remarks regarding your child's health, mental or emotional development you would like to call to our attention? _____

_____

_____

The answers to the above questions are correct.

Parent Signature:_____ Date: _____