2017 – 2018 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

TO WHOM IT MAY CONCERN:

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

that my child, _____
(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_____ _____ _____
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: _____
_____
_____

Home Phone: _____ Student's Date of Birth: _____

Insurance Company:_____

Policy/Membership Number:_____ Group #: _____

Policy Holder Name:_____

Allergies and/or Important Health Information:

_____
_____
_____
_____

This form must be completed every school year.

2017 – 2018 HEALTH INFORMATION

STUDENT NAME: _____

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

Frequent sore throats_____ Tires easily_____ Frequent earaches_____ Frequent stomachaches_____

Frequent headaches _____ Convulsion _____ Poor appetite_____ Frequent nosebleed_____

Frequent urination_____ Frequent sty's_____ Fainting spells_____ Pain in legs or joints_____

Shortness of breath _____

Diseases:

4 or more colds a year ___	German Measles ___	Poliomyelitis ___	Tonsillitis ___
Measles ___	Pneumonia ___	Ear Infections ___	Chicken Pox ___
Diabetes ___	Undulant Fever ___	Mumps ___	Eczema ___
Heart Disease ___	Asthma, Hay Fever ___	Hernia (rupture) ___	

Other ___ Please explain: _____

List any operation, injuries or deformities:

_____

Most recent examinations:

Physical_____ Physician_____
Date Name

Dental_____ Dentist_____
Date Name

Eye Exam_____ Specialist/Physician_____
Date Name

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

Are there any remarks regarding your child's health, mental or emotional development should be brought to our attention?

_____

_____

_____

_____

The answers to the above questions are correct.

Parent Signature: _____ Date: _____