CEDAR UNIFIED SCHOOL DISTRICT #25
~~SCHOOL YEAR 2012-2013~~

# EMERGENCY AUTHORIZATION & MEDICAL INFORMATION

Student Name: __________________________ Date of Birth:_______________ Age:__________ Grade:___________ Teacher: ___________________

Mailing Address: ____________________________________________________________ Residential Address: ____________________________________________

PARENT OR GUARDIAN TO CALL IN CASE OF EMERGENCY ILLNESS OR ACCIDENT

Mother/Guardian:_________________________________ Home Phone#_____________ Work Phone#___________ Cell Phone#_______________

Father/Guardian:_________________________________ Home Phone#_____________ Work Phone#___________ Cell Phone#_______________

PLEASE LIST FOUR INDIVIDUALS WHO YOU AUTHORIZE TO ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED.

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CHILD'S HEALTH HISTORY

*Please circle YES or NO*

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | Yes | No | Anxiety | Yes | No | Arthritis | Yes | No | Asthma | Yes | No |
| Attn. Deficit Disorder | Yes | No | Bleeding Disorder | Yes | No | Behavior/Emotional Prob. | Yes | No | Cancer | Yes | No |
| Cerebral Palsy | Yes | No | Chemical Abuse | Yes | No | Chest/Lung Condition | Yes | No | Counseling | Yes | No |
| Depression | Yes | No | Diabetes | Yes | No | Eating Disorder | Yes | No | Hearing Loss | Yes | No |
| Heart Condition | Yes | No | High Blood Pressure | Yes | No | Hypoglycemia | Yes | No | Kidney Problem | Yes | No |
| Learning Disabilities | Yes | No | Migraine Headaches | Yes | No | Pregnant | Yes | No | Restrictions | Yes | No |
| Seizure Disorder | Yes | No | Sinus Problems | Yes | No | Stomach Problems | Yes | No | Vision Deficit | Yes | No |
| Rheumatic Fever | Yes | No | Bone Fracture | Yes | No | Chicken Pox | Yes | No | Measles | Yes | No |

If any YES circled, please comment: ___________________________________________________________________________________________
Surgeries/Hospitalization or any other problems: _______________________________________________________________________________
Does your child take daily medications(s)? Please circle YES or NO. If YES list drug, dose and times (this includes inhalers): ________________________________
Family Doctor: __________________________________ Phone#________________________________ Hospital Preference:_____________________________

1. I the undersigned do hereby authorize officials at Cedar School District #25 to contact directly the persons name on this form and do authorize the emergency room physician at the closest, most appropriate health care facility to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event the persons named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child; I will not hold the Cedar School District financially responsible for the emergency care and/or transportation of said child.
2. I give the school secretary permission to examine my child at the school if he/she becomes ill or injured and provided necessary nursing treatment. In addition, I give permission for my child to participate in routine programs for vision, hearing, height, and weight, scoliosis and lice. I understand these services are part of school health programs throughout Arizona.

_______________________________________________ ________________________________________

Parent/Guardian Signature Date