

**EMERGENCY MEDICAL AUTHORIZATION**

**Purpose** – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information may be shared with the educational team to best meet your child's needs.

Student Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address Change Y N Birth Date \_\_\_\_\_  
 Social Security \_\_\_\_\_

Phone # \_\_\_\_\_ Bus # \_\_\_\_\_  
 School District \_\_\_\_\_  
 School Attending Central Catholic High School  
 Sex M F Grade \_\_\_\_\_ Home Room \_\_\_\_\_

**Residential Parent or Guardian:** **\*\*Email:** \_\_\_\_\_  
 Mother \_\_\_\_\_ Day Ph # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Father \_\_\_\_\_ Day Ph # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Ph # \_\_\_\_\_  
 Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Ph # \_\_\_\_\_

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

Doctor \_\_\_\_\_ Phone # \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone # \_\_\_\_\_  
 Medical Specialist \_\_\_\_\_ Phone # \_\_\_\_\_  
 Hospital \_\_\_\_\_ Phone # \_\_\_\_\_

**Check below any CURRENT health condition that may require attention during the school day:**

- Allergies (be specific)
  - Food \_\_\_\_\_ EpiPen Yes No
  - Medicine \_\_\_\_\_
  - Bee sting \_\_\_\_\_ EpiPen Yes No
  - Other \_\_\_\_\_
- Asthma **Uses emergency inhaler** Yes No  
**Inhaler will be at school** Yes No
- Cancer
- Diabetes
- Seizures
- Heart problems (be specific) \_\_\_\_\_
- Physical disability (be specific) \_\_\_\_\_
- List all medications and dosages your child receives on a continual basis: \_\_\_\_\_
- Other health conditions (be specific) \_\_\_\_\_
- Previous surgeries (include date) \_\_\_\_\_
- Previous concussion/head injury – year \_\_\_\_\_
- Hearing problems Has hearing aids Yes No
- Vision problems (be specific) \_\_\_\_\_  
 Wears:  Glasses  Contacts
- ADHD
- Behavior/emotional problems \_\_\_\_\_
- Bleeding Disorder
- NO CURRENT HEALTH CONDITIONS**

**PLEASE COMPLETE PART I OR PART II - NOT BOTH**

**Part I – TO GRANT CONSENT**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the designated physician or dentists, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_

**Part II – REFUSAL TO 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 \_\_\_\_\_ Parent or Guardian REFUSAL Signature \_\_\_\_\_

## Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

### Symptoms may include one or more of the following:

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Headaches</li><li>• "Pressure in head"</li><li>• Nausea or vomiting</li><li>• Neck pain</li><li>• Balance problems or dizziness</li><li>• Blurred, double, or fuzzy vision</li><li>• Sensitivity to light or noise</li><li>• Feeling sluggish or slowed down</li><li>• Feeling foggy or groggy</li><li>• Drowsiness</li><li>• Change in sleep patterns</li></ul> | <ul style="list-style-type: none"><li>• Amnesia</li><li>• "Don't feel right"</li><li>• Fatigue or low energy</li><li>• Sadness</li><li>• Nervousness or anxiety</li><li>• Irritability</li><li>• More emotional</li><li>• Confusion</li><li>• Concentration or memory problems (forgetting game plays)</li><li>• Repeating the same question/comment</li></ul> |
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### Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions.

#### Student

Student Name (Print): \_\_\_\_\_ Grade: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Parent or Legal Guardian

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_