TROTWOOD-MADISON CITY SCHOOLS
Medical Update Form
(*PLEASE USE BLUE OR BLACK PEN*)
2017 - 2018

Dear Parent/Guardian:

Please fill in the following information needed to update your child's medical records for this school year. We appreciate your immediate attention to this matter. **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.** Thank you. **(PLEASE PRINT)**

Student Name _____ Sex ___ Grade___
Date of Birth _____ Address _____
Home Phone _____ Cell Phone _____
Mother's Name _____ Work Phone _____
Father's Name _____ Work Phone _____
Parent's Email _____

EMERGENCY MEDICAL AUTHORIZATION

Please identify any health concerns that school personnel should be aware of:

Allergies: No ___ Yes ____ ***If yes, specify*** _____

Epi-pen: No ___ Yes____ ***If yes, Epi-pen Authorization Form must be completed.***

Asthma: No ___ Yes ____ ***If yes, Inhaler Authorization Form must be completed.***

Seizures: No ___ Yes ____ ***If yes, Emergency seizure medications?*** _____

Diabetes: No___ Yes ___ ***If yes, Emergency diabetic medications?*** _____
(Name of medications)

Student on an IEP with Special Health Care need *(e.g. asthma, diabetes, seizure disorder, severe allergy, etc.)*? If so please explain _____

Does the student take any medication regularly? ___ No ___ Yes, Specify _____
(Name of medication, amount taken, how often)

Will the student take medication at school? ___No ___Yes; ***If yes, Permission to Dispense Medication Form must be completed.***

Are there any other medical conditions that school personnel should be aware of? _____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor _____ Phone _____
Dentist _____ Phone _____
Medical Specialist _____ Phone _____
Local Hospital/Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) The principal or his/her designee to transport and seek emergency medical or dental treatment; I understand that Trotwood-Madison, its employees and its Board of Education assume no liability of any nature in relationship to transportation or treatment of the said minor; I further understand that all costs of EMS transportation, hospitalization, examination, x-ray or treatment provide in relation to this authorization shall be my responsibility. This authorization shall remain effective for the full school year unless revoked in writing and delivered to Trotwood-Madison School District.

_____
Signature of Parent/Guardian **Date**

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 the following action:

_____
_____
_____
_____

_____
Signature of Parent/Guardian **Date**