**TROTWOOD-MADISON CITY SCHOOLS**

**Medical Update Form**

**(*PLEASE USE BLUE OR BLACK PEN*)**

2019-2020

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 phPhone |  |  |  |
| Father’s Name |  |  |  | Work Phone |  |  |  |
| Parent’s Email address |  |  |  |  |  |  |  |

**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 Dentist

Medical Specialist

Local Hospital/Emergency Room Phone

Phone

Phone

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**

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