OUR LADY OF FATIMA PARISH SCHOOL
ALLERGY/MEDICAL INFORMATION AND MEDICAL TREATMENT AUTHORIZATION FORM

STUDENT NAME: _____

Grade: _____ **School Year:** _____

MEDICAL/BEHAVIORAL CONDITIONS/PHYSICAL LIMITATIONS/ALLERGIES (e.g., asthma, diabetes, food or seasonal allergies)? Please list required medication(s) and/or treatment plan:

Please Note: An Authorization for Administration of Medication at School form is required each school year.

Dietary restrictions? If yes, please list: _____

_____

Allergies to medications? If yes, please list: _____

_____

PEDIATRICIAN: _____ **Phone:** _____

DENTIST: _____ **Phone:** _____

OTHER: _____ **Phone:** _____

MEDICAL INSURANCE:

Insurer:_____Member#: _____ Group#: _____

DENTAL INSURANCE:

Insurer:_____Member#: _____ Group#: _____

PREFERRED HOSPITAL: _____

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILD

I, _____ (parent/guardian), hereby give permission that my child, _____, may be given emergency treatment to include first aid and CPR by a qualified child care or school staff member of Our Lady of Fatima Parish School.

In the event that I cannot be contacted, I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician or dentist, or when that physician cannot be reached, 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 care to an emergency care center for treatment.

Parent/Guardian Name:_____ **Phone:** _____
Please print

Signature of Parent/Guardian: _____
Date