

**2011-2012 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE**

**TO WHOM IT MAY CONCERN:**

I \_\_\_\_\_ (the natural parent or legal guardian)  
Print

hereby give permission that my Child, \_\_\_\_\_  
First Middle Last

may be given emergency treatment to include first aid and CPR by a qualified emergency medical or first aid caregiver. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child 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 car to an emergency center for treatment.

Name \_\_\_\_\_  
Signature Relationship Date

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Phone Numbers:**

_____ Name	_____ Relationship	_____ Phone Number	_____ Cell Phone
_____ Name	_____ Relationship	_____ Phone Number	_____ Cell Phone
_____ Name	_____ Relationship	_____ Phone Number	_____ Cell Phone

Student Home Address \_\_\_\_\_  
Number and Street City State Zip Code

Home Phone \_\_\_\_\_ Student's Birth date: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy/Membership Number \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_  
City State Zip Code

Allergies \_\_\_\_\_

# 2011-2012 HEALTH INFORMATION

STUDENT NAME \_\_\_\_\_

Please check any of the following symptoms that have been noted:

Frequent sore throats \_\_\_\_\_ Tires easily \_\_\_\_\_ Frequent earaches \_\_\_\_\_ Frequent stomachaches \_\_\_\_\_

Frequent headaches \_\_\_\_\_ Convulsion \_\_\_\_\_ Poor appetite \_\_\_\_\_ Frequent nosebleed \_\_\_\_\_

Frequent urination \_\_\_\_\_ Frequent sty's \_\_\_\_\_ Fainting spells \_\_\_\_\_ Pain in legs or joints \_\_\_\_\_

Shortness of breath \_\_\_\_\_

**Diseases:**

4 or more colds a year \_\_\_\_\_ German Measles \_\_\_\_\_ Poliomyelitis \_\_\_\_\_ Tonsillitis \_\_\_\_\_

Measles \_\_\_\_\_ Pneumonia \_\_\_\_\_ Ear Infections \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Diabetes \_\_\_\_\_ Undulant Fever \_\_\_\_\_ Mumps \_\_\_\_\_ Eczema \_\_\_\_\_

Heart Disease \_\_\_\_\_ Asthma, Hay Fever \_\_\_\_\_ Hernia (rupture) \_\_\_\_\_

Other \_\_\_\_\_

List any operation, injuries or deformities \_\_\_\_\_

**Most recent examinations:**

Physical \_\_\_\_\_ Physician \_\_\_\_\_  
Date

Dental \_\_\_\_\_ Dentist \_\_\_\_\_  
Date

Eye Exam \_\_\_\_\_ Specialist/Physician \_\_\_\_\_  
Date

Has your child ever been around anyone known to have Tuberculosis? \_\_\_\_\_

Are there any remarks regarding your child's health, mental or emotional development you would like to call to our attention?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent Name \_\_\_\_\_

Printed

Parent Signature

Date