

2018 - 19 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

TO WHOM IT MAY CONCERN:

I _____ (the natural parent or legal guardian) hereby give permission that my child, _____
(Print Legal Guardian's Name) (Please Print Child's First Child's Middle Child's 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: _____
Parent/Guardian Signature Relationship to child Date

Witness: _____
Signature Date

Emergency Phone Numbers:

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

Student Address:

House Number and Street Address

City State Country Postal Code

Student's Information:

Student's Date of Birth: _____

Insurance Company: _____

Policy/Membership #: _____ Group #: _____

Policy Holder Name: _____

Allergies and/or Important Health Information: _____

2018-19 HEALTH INFORMATION

STUDENT NAME: _____

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

- Frequent sore throats Tires easily Frequent earaches Frequent stomach aches
 Frequent headaches Poor appetite Frequent nosebleeds Shortness of breath
 Fainting spells Pain in legs or joints Other: _____

Diseases: *Please check any of the following that the student has or had.*

- 4 or more colds a year Measles Poliomyelitis Tonsillitis
 Pneumonia Ear Infections Chicken Pox Diabetes
 Mumps Eczema Heart Disease Asthma/Hay Fever
 Hernia (rupture) Other: _____

Please explain: List any operation, injuries or deformities:

Physical Date: _____ Physician: _____

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? _____

The answers to the above questions are correct.

Parent Signature: _____ Date: _____