Authorization to Treat a Minor with Medical History

Student Name:_____ D.O.B.:_____Grade:_____School Year:_____

I (we) the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medial or surgical diagnosis in treatment rendered under the general or special supervision of any member of the medical staff or emergency room staff licensed under applicable law of any hospital holding a current license to operate unapplicable law. It is understood that this authorization is given to provide authority and power to render care which aforementioned physician in the exercise of his/her best judgment may deem advisable. It is further understood that an effort shall be made to contact the undersigned prior to rendering treatment to patient, but that in an emergency situation, necessary treatment will not be withheld if the undersigned cannot be reached. ***This form remains in effect the entire time your child is in the Genoa Central School District.***

List any restrictions:_____

_____

Current medical condition (Such as ADD/ADHD, asthma, etc.) If your child has a condition that requires frequent bathroom trips we must have a note from the MD:_____

Non-prescription or **Prescription** medications currently taking:_____

_____

If your child is to take medications at school, you must see the nurse to fill out the required paperwork. (This includes asthma inhalers.) Also if your child is given medication throughout the year (antibiotics, eardrops, etc.) to be given 3 times a day, you should give it before school, right after school, and at bedtime. This eliminates the possibility of the medicine being left at school and not accessible for other doses.

Drug sensitivity and **allergies** (list and describe reaction):	Any **food**, **cosmetic,** or **other allergies** (list and describe):
_____ _____	_____ _____

Has your child ever received medical treatment for any of the following:

Condition/Illness	Circle	Describe	Condition/Illness	Circle	Describe
Heart trouble	yes no		Seasonal allergies	yes no	
Asthma	yes no		Sinus problems	yes no	
Anemia	yes no		Headaches/Migraines	yes no	
Diabetes	yes no		Insect stings	yes no	
Seizures	yes no		Depression/ anxiety	yes no	
Vision problems Wear Glasses/Contacts	yes no		Ear/Hearing problems	yes no	
Kidney/ bladder problems	yes no		Blood pressure high/low	yes no	
Handicaps/Disabilities	yes no		Life-threatening conditions	yes no	

Describe any current or past medical treatment **NOT** listed above:_____

_____

Telephone numbers where parents/guardians may be reached:

Father	( ) -	( ) -
Mother	( ) -	( ) -
ER Contact #1: Name:	( ) -	( ) -
ER Contact #2: Name:	( ) -	( ) -

Physician (Name)_____ Address:_____Phone_____

Insurance Co._____Policy Number_____

Signature of Parent/Guardian_____Date:_____

Address City State Zip

Note: If my child's temperature reaches 102 F or above and there is a delay in contacting me or transporting my child home, I hereby give my permission for Tylenol to be administered.

Signature of Parent/Guardian_____