# THIS FORM IS FOR PRESCHOOL STUDENTS ONLY

## 2025 - 2026 EMERGENCY MEDICAL AUTHORIZATION

**This form must be filled out and returned on or before the first day of school**

SCHOOL DISTRICT: Archdiocese of Cincinnati

SCHOOL ATTENDING: **Our Lady of the Visitation**

**(PLEASE PRINT):**

STUDENT'S LAST NAME ______________________________

STUDENT'S FIRST NAME __________________________

DATE OF BIRTH ___________________ GRADE _________

HOMEROOM TEACHER ____________________________

HOME ADDRESS ____________________________________

HOME PHONE ____________________________________

MOTHER'S NAME ___________________________________

FATHER'S NAME _________________________________

MOTHER'S CELL ____________________________________

FATHER'S CELL __________________________________

MOTHER'S EMAIL ___________________________________

FATHER'S EMAIL _________________________________

**In the event of an emergency or to verity the absence of my child from school (if the school has not been notified by 8:30 a.m.) PLEASE CONTACT:**

1. ___________________________ ____________________ _________________ ___________________________________
   Name Relation Phone # Email Address

2. ___________________________ ____________________ _________________ ___________________________________
   Name Relation Phone # Email Address

2. ___________________________ ____________________ _________________ ___________________________________
   Name Relation Phone # Email Address

**PART I OR II MUST BE COMPLETED**
**PART 1 TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name ______________________________________ Phone # __________________________________

Dentist's Name ______________________________________ Phone # __________________________________

Local Hospital ______________________________________ ER Phone # ________________________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

____________________ ______________________________________________________________

Date Signature of Parent or Guardian

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I**
**PART II**

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: _____________________________________________________

____________________ ______________________________________________________________

Date Signature of Parent or Guardian

**PLEASE COMPLETE OTHER SIDE**

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HAMILTON COUNTY EDUCATIONAL SERVICE CENTER

## STUDENT HEALTH HISTORY UPDATE

**STUDENT** ____________________ **GRADE** ________ **ROOM** ________

Please complete this form and return it to school as soon as possible. Having up-to-date health information allows better care and understanding of your child's needs if problems arise during the school day. If there are any future changes in your child's health status, please call the school nurse at 513-451-7207 or send a note to school. **Check all health conditions your child may have.**

☐ **ADD / ADHD (Please circle)**

☐ **ALLERGIES** or reactions to: (Please explain)

Food(s) ____________________

Medication(s) ____________________

Plant / Animal / Environmental / Seasonal__________

____________________

____________________

☐ **ASTHMA** (Identify triggers)

____________________

____________________

Has your child ever needed <u>emergency</u> treatment for asthma?

___ YES ___ NO

☐ **BLADDER PROBLEMS** (Please explain)

____________________

☐ **BOWEL PROBLEMS** (Please explain)

____________________

☐ **CYSTIC FIBROSIS**

☐ **DIABETES** Age of diagnosis ____________

☐ **EAR INFECTIONS** (frequently after age of 3)

Approximate date <u>or</u> age of last infection ________

Currently under the care of ENT? ___ YES __ NO

Currently has PE tubes? ___ YES ___ NO

Date of last ENT appointment _________________

☐ **EATING DISORDER**

☐ **EMOTIONAL/ BEHAVIORAL CONCERNS**

☐ **EYE PROBLEMS** (Please explain)

____________________

Wears glasses/contacts? ___ YES ___ NO

Date of last eye examination _______________

☐ **HEADACHES** (frequent)

Migraines? ___ YES ___NO

☐ **HEART CONDITION** (Please explain)

____________________

☐ **KIDNEY DISEASE** (Please explain)

____________________

☐ **MENSTRUAL PROBLEMS** (Please explain)

____________________

☐ **PHYSICAL DISABILITY** (Please explain)

____________________

____________________

☐ **RECENT HOSPITALIZATION/SURGERY**

**SIGNIFICANT INJURY** (Please explain)

____________________

☐ **SICKLE CELL DISEASE** (not trait)

Date of last sickle cell crisis ________________

☐ **SEIZURES / EPILEPSY**

Date of last episode ______________________

☐ **SPINAL CURVATURE** (scoliosis, etc. )

Currently under the care of an orthopedic doctor?

___ YES ___ NO

☐ **TICS / NERVOUS TWITCHES**

My child takes the following <u>daily</u> medication(s) ____________________

My child takes the following medication(s) <u>occasionally</u> ____________________

Please identify any other health information not listed above that you believe school personnel need to be aware of______________

____________________

☐ **NONE OF THE ABOVE APPLIES TO MY CHILD.** This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

**Parent/Guardian Signature**____________________ **Date** _________

**PLEASE COMPLETE OTHER SIDE**