



## Medical Emergency Information and Consent Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

(for children only) Mother's/ Guardian's Name: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_

Father's/ Guardian's Name: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_

Child resides with: \_\_\_\_\_  
Name and relationship to child

### MEDICAL HISTORY

Diagnoses: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Allergies: \_\_\_\_\_

Other facts concerning your child's medical history: \_\_\_\_\_

### EMERGENCY CONTACT

Please specify three alternate emergency contacts that can provide transportation in the event the parent/guardian is unavailable:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  can provide transportation

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  can provide transportation

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  can provide transportation

### HEALTHCARE INFORMATION

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

A message may be faxed or left on my answering machine  YES  NO

Verbal information may be shared with a caregiver other than myself  YES  NO

I give my permission for MCBMRDD nursing staff to share information with the physician, dentist, or other health care professional as indicated in the individual's record  YES  NO

I give my permission for a licensed nurse or trained MCBMRDD staff to administer medications, tube feedings, emergency medical interventions, and/or medical treatments per physician's order while child attends Board programs  YES  NO

### PLEASE NOTE

- Board services shall not be provided unless a current signed Student Medical Emergency Information and Consent Form is on file for the student.
- This Student Medical Emergency Information and Consent Form is valid for one year from date signed below.
- In the event of an emergency, 911 will be called to transport the student for medical care to Medina General Hospital.
- This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for each surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature

Date

Copies to MCBMRDD direct care staff (e.g. transportation drivers, work supervisors, job coaches, teachers, etc.)