Medical Authorization/Medical Information

Name _____ Birthdate _____
Last First Middle

Parent(s)/Legal Guardian(s) _____
Please include full names, NOT Mr. And Mrs.

In case of emergency, please contact (include parent/guardian):

(1)_____ phone #_____ relationship _____

(2)_____ phone #_____ relationship _____

(3)_____ phone #_____ relationship _____

Current or ongoing health concerns _____

Current medications _____

Allergies to medicines: _____

Other allergies: _____ **Dates of Last Tetanus:** _____

Does our child have/use an EPI pen? _____

Does your child:

Yes	No	Yes	No	Yes	No
____	____Frequent nose bleeds	____	____Wears glasses or contacts	____	____Hernia
____	____Heart condition	____	____Has speech problems	____	____Asthmatic
____	____High blood pressure	____	____Has hearing problems	____	____Diabetic
____	____Leg or knee injuries	____	____Sickle cell trait/Anemia	____	____Skin problems
____	____Seizures/convulsions	____	____Physically handicapped	____	____Migraines
____	____Wears dental appliances	____	____Had back or neck injuries	____	____Kidney Problems

Other medical information _____
_____
_____

I, as the parent or legal guardian, give authorization to the adult person in charge of the first aid administration, whom has checked this form for permission, my consent to administer the over the counter medications checked below:

____ **All** of the medications listed below **or** ____ **Only** those medications marked below

- ____ Tylenol or generic equivalent
- ____ Ibuprofen, Motrin, Advil or other equivalent
- ____ Benedryl or generic equivalent
- ____ Tums, Rolaids or generic equivalent
- ____ Pepto Bismal or generic equivalent
- ____ Neosporin or generic equivalent

Please note any over the counter medication that your child is NOT allowed to have access to due to unusual or allergic reactions:

_____

_____

Medical Authorization

I, the undersigned, being the parent or legal guardian of _____ a minor, hereby appoint and authorize officials or designees of the Bartow County School System, Cass High School, and/or the Cass High School Band to administer those medications indicated above and/or to act for me and my behalf to execute a consent to emergency care for such minor child to physicians, hospitals or other health care facilities as may be deemed appropriate by the above named appointee for such physicians, hospitals or other health facilities to render such care, including diagnostic procedures, surgical and medical treatments as may be deemed necessary for the emergency treatment of said minor. I further understand that proof of adequate medical insurance should be provided. The undersigned does further agree to be responsible for, and to pay, all charges and fees incurred for such service not covered by an applicable policy of insurance.

_____ _____
Parent or guardian written name Parent or guardian signature Date

Health Insurance Coverage

_____ I currently have adequate medical insurance to cover any incident involving my child.
Parent/guardian initials

Health Insurance Provider _____