St. Mary Catholic School

MEDICAL AUTHORIZATION

Student Name _____ Homeroom # _____ Date of Birth ____/____/_____

Address _____ Telephone (____)_____

City _____ Zip _____

Purpose--To enable parents/ guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent/ Guardian:

Mother's Name_____ Day Phone (____)_____Cell (_____)_____

Email _____

Father's Name_____ Day Phone (____)_____Cell (_____)_____

Email _____

Other's Name _____ Day Phone (_____)_____Cell (_____)_____

Email _____

Name of Relative/ Childcare Provider:

Name_____ Relationship_____ Day Phone (_____)_____

Address_____ City_____ Zip_____

Residential Parent/ Guardian:

Mother living with family? ___Yes ___No Father living with family? ___Yes ___No

My child may be released to: _____

Do not release my child to: _____

PART I OR II MUST BE COMPLETED

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

Physician _____ Phone (_____)_____

Dentist _____Phone (_____)_____

Medical Specialist _____Phone (_____)_____

Local Hospital _____ Emergency Room Phone (_____)_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) Administration of any treatment deemed necessary by above-names doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) 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. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

Signature of Parent/Guardian _____ Date _____

PART II: REFUSAL TO CONSENT - *DO NOT COMPLETE PART II IF YOU COMPLETED PART I*

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:

_____

Signature of Parent/Guardian _____ Date _____

Physician to complete

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone			
Right ear	☐ Pass	☐ Fail	
Left ear	☐ Pass	☐ Fail	
Child wears hearing aid?	☐ Yes	☐ No	
Child under the care of a hearing specialist	☐ Yes	☐ No	
Referral made?	☐ Yes	☐ No	

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments _____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No
Child has possible problem with _____		

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL

Tuberculin Test
Date _____ Type _____ Results _____

Hemoglobin Test Date: _____ **Results** _____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Immunization

Student _____ **Birthdate**_____

Ohio Law – Areas Required Must be Completed for School Entry

Type	Date-Month/Day/Year					
DtAP, DPT or DT	Required	Required	Required	Required	Required	5th dose required if 4th dose given before age 5
DT/Td						
Polio	Required	Required	Required	Required	4th dose requied if 3rd dose given before age 4	
Measles, Mumps, Rubella (MMR)	Required	Required				
Hib-Hemophilus Inflluenzae B (prior to age 5 only)				0-14 mos. 3-4 doses 15-59 mos. 1 dose		
Hepatitis B	Required	Required	Required			
Varicella	Required					
Tuberculin Test						
Rotavirus (given at 2-4-6 mos., not after 12 mos.)						
Other						

Verified by _____ **Date** _____