Tempe★Union
HIGH SCHOOL DISTRICT

Medical Emergency Information Form

In the event of illness or injury occurring to my student while on this travel/activity, I hereby give my consent for medical or dental care deemed necessary by the attending health care provider or dentist. My child may be examined and any necessary procedures (medical, dental, surgical), anesthesia or diagnostic procedures (lab or x-ray) may be performed under the supervision of a member of the hospital or medical office staff furnishing such services.

I further acknowledge that I am financially responsible for any medical, dental, ambulance or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury. I also acknowledge that I may obtain accident insurance through the school if I do not currently have family medical insurance.

I understand that, in the event of other that minor illness or injury, responsible effort will be made to contact me.

Parent/Guardian Name: _____ Contact Number: _____

Parent/Guardian Name: _____ Contact Number: _____

Emergency Contacts, if Parent/Guardian is unable to be reached:

Name: _____ Contact Number: _____

Name: _____ Contact Number: _____

Physician's Name: _____ Phone: _____

Hospital Preference: _____

Insurance Carrier: _____ Phone: _____

Group Number: _____

- Do you authorize a certified district employee or Principal's designee to give your child acetaminophen or ibuprofen? **YES** _____ **NO** _____ **Additional info:** _____
- Specify health problems/allergies: _____
- Is your child on daily medication? **NO** _____ **YES** _____ ***if yes, complete the consent below***
- Other limitations or concerns: _____

Consent for Giving Medication

I hereby request and give my consent for a certified district employee or Principal's designee to see that my child receives the medication as listed below:

Medication		**Time(s) to Give:**		**Date(s):**	
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Prescription medication must be in the original container as prepared by a pharmacist and fully labeled. Over the counter medication must also be in its original packaging that is fully labeled.

_____ _____

Signature - Parent/Guardian Date