KUNA SCHOOLS EMERGENCY MEDICAL INFORMATION

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for student-athletes who become ill or injured while under school authority, when parents or guardians cannot be reasonably reached.

NAME (last) _____ (first) _____ (mi) _____ GRADE ____ DATE _____
ADDRESS _____ M or F AGE_____ DOB_____/_____/_____
CITY _____ ZIP _____ PHONE _____ SSN:_____
FATHER'S NAME _____ PHONE_____ EMPLOYER_____ PHONE_____
MOTHER'S NAME _____ PHONE _____ EMPLOYER_____ PHONE_____

Name and phone of person other than parent/guardian who is authorized to approve emergency medical treatment:
NAME_____ Phone_____
FAMILY DOCTOR _____ PHONE_____
FAMILY DENTIST_____ PHONE_____
HEALTH INSURANCE CO._____ POLICY #_____ PHONE_____

IN THE EVENT REASONABLE ATTEMPTS TO CONTACT ME/US AT ABOVE LOCATIONS, OR OTHER PERSONS NAMED ABOVE, FULL AUTHORIZATION IS GIVEN FOR (1) THE ADMINISTRATION OF ANY TREATMENT DEEMED TO BE NECESSARY BY A LICENSED TRAINER, OR MEDICAL PRACTITIONER, AND (2) THE TRANSFER OF SON/DAUGHTER OR WARD TO ANY LICENSED TRAINER, OR MEDICAL PRACTITIONER; AND (3) THE TRANSFER OF SON/DAUGHTER OR WARD TO ANY LICENSED HOSPITAL OR EMERGENCY CLINIC REASONABLY ACCESSIBLE. IT IS UNDERSTOOD THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS, TREATMENT OR HOSPITAL CARE BEING REQUIRED, BUT IS GIVEN TO PROVIDE AUTHORITY AND POWER ON THE PART OF SCHOOL AUTHORITIES AND AFORESAID AGENT(S) TO GIVE REASONABLE CARE. FACTS ARE GIVEN BELOW CONCERNING THE STUDENT'S MEDICAL HISTORY WHICH A MEDICAL PRACTITIONER SHOULD KNOW.

BLOOD TYPE_____ALLERGIES_____ALLERGY SPECIFIC MEDICATION(S)
GLASSES OR CONTACTS: Y N FALSE TEETH OR BRIDGEWORK: Y N LAST TETANUS BOOSTER:
ANY PREVIOUS SIGNIFICANT MEDICAL PROBLEMS_____
DATE: _____SIGNATURE OF PARENT/GUARDIAN:_____