ST. JOHN THE EVANGELIST SCHOOL
8912 OLD BRANCH AVENUE
CLINTON, MARYLAND 20735
301-868-2010
www.saintjohnsschool.org

EMERGENCY MEDICAL AUTHORIZATION

2023-2024

STUDENT NAME _____ Grade_____

ADDRESS _____

There are times in the school year when a child becomes ill or is hurt and medical attention is necessary. It is school policy to contact the parents/guardians first, and if this is not possible, to contact another authorized person or physician based on given information.

- Do you give permission for your child to receive aid for minor illnesses and injuries while in school? This first aid will be administered by a Nurse or Medication Technician.
  YES_____ NO_____
- In case of an emergency and you cannot be contacted, nor your authorized persons, do you want your family physician called? YES_____ NO_____

  Name of Physician _____ **Phone No.** _____

  Preferred Hospital _____

- If neither you nor your family physician can be contacted, may school officials act for you until you or your physician is contacted? This might include calling 911 and/or taking your child to the hospital. If the student is transported by ambulance, the school nurse or medication technician will accompany the student. YES_____ NO _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Name Printed _____

Father/Guardian's Name _____ Home #_____

Email_____ Cell #_____

Work #_____

Mother/Guardian's Name _____ Home #_____

Email_____ Cell #_____

Work #_____

****Who should the Office contact first?** Please circle Mother Father

The Office will make every attempt to contact the requested parent first. If that parent is not available, the second parent will be contacted. If neither parent is accessible, an alternate authorized adult must be available. Sick children **MUST** be picked up within an hour of notification. (St. John's School Handbook, pg. 20)

Authorized Person #1_____ Phone# _____

Relationship to student _____

Authorized Person #2_____ Phone# _____

Relationship to student _____

INFORMATION FOR SCHOOL HEALTH RECORDS

Please list any ALLERGIES and the REACTION your child may have.

ALLERGY	REACTION	DOES ALLERGY REQUIRE EPIPEN or AUVIQ?	
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO

Please list any medication your student is taking, including dose, time, route, and reason for medication.

_____

_____

_____

_____

Please list any other medical conditions not mentioned previously.

_____

_____

_____

_____

I have reviewed and understand the conditions of the emergency medical authorization form.

Parent/Guardian Signature _____ Date _____