BISHOP CONNOLLY
HIGH SCHOOL

373 Elsbree Street
Fall River, MA 02720
tel 508.676.1071
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AUTHORIZATION FOR MEDICAL TREATMENT FORM 2018 – 2019

PLEASE FILL OUT **BOTH** SIDES.

Please fill in the following information, which is important in the case of serious illness or emergency.
Please notify the school nurse of any changes in student health history or medication.

STUDENT FIRST NAME _____ STUDENT LAST NAME _____

PARENT/GUARDIAN FIRST NAME _____ PARENT/GUARDIAN LAST NAME _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ALTERNATE EMERGENCY CONTACT FIRST NAME _____ ALTERNATE EMERGENCY CONTACT LAST NAME _____ RELATIONSHIP TO STUDENT/ATHLETE _____

ALTERNATE EMERGENCY CONTACT HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PHYSICIAN NAME _____ PHYSICIAN PHONE _____

Please check if the student has any of the following:
❑ DIABETES ❑ EPILEPSY ❑ HEART CONDITION ❑ ASTHMA ❑ HIGH BLOOD PRESSURE OTHER_____

Does the student wear contact lenses? ❑ YES ❑ NO

Please list all current medications, including inhalers, and directions for use:

_____

_____

_____

Please list all allergies, including medications, foods and insects. Describe the allergic reaction:

_____

_____

_____

Please list any other pertinent medical information:

_____

_____

_____

Please provide insurance information:

POLICY NAME _____ POLICY NUMBER _____ SUBSCRIBER'S NAME _____

PARENT/GUARDIAN PERMISSION

I wish my child to be allowed to receive 1–2 ibuprofen tablets, extra-strength Tylenol tablets, or Tums from the school nurse or school personnel designated by the school nurse. I also grant to Bishop Connolly High School and its agents, my permission to seek emergency medical attention for my child if, in their judgment, such attention is warranted and I am not immediately available to grant such permission.

Yes / No

I give permission for the school nurse to share pertinent medical information with the school staff.

Yes / No

I give my child permission to participate in athletics at Bishop Connolly High School and use the transportation provided by the school. I give my permission for the evaluation/treatment of my child by the certified athletic trainer and any duly licensed physician and/or hospital facility in the event of illness or injury.

Yes / No

I give permission for the Bishop Connolly High School medical staff to share any pertinent medical information concerning my son or daughter to EMTs, team, or other physicians, in relation to any incurred injury or illness sustained by student-athlete during participation.

Yes / No

I authorize transportation in an ambulance of my child, if necessary. I verify that the responses on the Authorization for Medical Treatment Form 2017–2018 are true to the best of my knowledge.

Yes / No

PARENT/GUARDIAN SIGNATURE DATE