Alternative Paths Training School & Consulting
EMERGENCY CARE & MEDICAL AUTHORIZATION

ECMAv10312011

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent/guardian or a designated emergency contact.
(To Be Completed By Parent/Guardian Each School Year AND When Changes Occur)

STUDENT INFORMATION

Last Name:	First Name:	Grade: _____ School Year: _____ Social Security #:
Middle Name:	Other (Nick) Name:	APTS ID#: (Office use only)
Date of Birth:	Gender: ☐ Male ☐ Female	Language spoken at home:

Student resides with: ☐ Father ☐ Mother ☐ Both Parents ☐ Legal Guardian ☐ Residential / Group Home

PARENT/GUARDIAN CONTACT NFORMATION

FATHER	Last Name:	Address:	Home Phone:
First Name:			Work Phone:
Middle Name:	Language:	Email:	Cell Phone:
MOTHER	Last Name:	Address:	Home Phone:
First Name:			Work Phone:
Middle Name:	Language:	Email:	Cell Phone:
GUARDIAN	Last Name:	Address:	Home Phone:
First Name:			Work Phone:
Middle Name:	Language:	Email:	Cell Phone:
RESIDENTIAL Mgr.	Last Name:	Address:	Home Phone:
First Name:			Work Phone:
Middle Name:		Email:	Cell Phone:

DESIGNATED ALTERNATE (If I cannot be reached, the following persons are AUTHORIZED to act on my behalf)

#	Name of Person	Relationship	Language Preferred	Telephone
1				
2				

THE FOLLOWING PERSONS ARE AUTHORIZED TO **PICK UP** MY CHILD (Must be one of those listed above with contact information)

1.	2.
3.	4.

PHYSICIAN INFORMATION

Name of Preferred Medical Doctor/Medical Facility:	Telephone:

HEALTH INSURANCE INFORMATION

Policyholder's Name:	Policy#:
Name of Health insurance company/Provider:	Telephone

CURRENT HEALTH CONDITIONS (Part1)

Check any current health condition that may require attention during the school day.

Primary Diagnosis: _____

Secondary Diagnosis: _____

Date of last Tetanus Shot: _____

☐ Allergies (be specific):

- ☐ Foods_____
- ☐ Medicines_____
- ☐ Bee Sting/Insects _____
- ☐ Other _____ ☐ Has Epi-pen

☐ Pulmonary (Respiratory, Asthma, etc. Be specific): _____

☐ Cancer ☐ Diabetes ☐ Hearing Problems

☐ Cardiovascular/Heart Problems (be specific): _____

Other pertinent facts to which a medical doctor should be alerted:

☐ Blood Disorders/Hemophilia

☐ Seizure disorder ☐ Incontinence

☐ Chronic Condition/Long term illness (es): _____

☐ Physical disability/impairments (be specific): _____

_____

☐ Special Equipment (be specific):

- ☐ Gait Belt ☐ Hearing Aid(s) ☐ Contact Lenses
- ☐ Helmet ☐ Wheelchair ☐ Dentures / Braces
- ☐ Eye Glasses ☐ Orthotics ☐ Nebulizer
- ☐ Glucometer ☐ Peak Flow Monitor
- ☐ Other: _____

If you checked any of the above, complete CURRENT HEALTH CONDITIONS (Part2) ➔

Student Last Name:	Student First Name:	Grade: ______ School Year: _______ Social Security #:

CURRENT MEDICATIONS

List all medications your child receives on a continual basis.

Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School
Name Of Medication:	Purpose / Diagnosis:	Start Date:	Med Type: ☐ OTC ☐ Prescribed
Med Description: (e.g., round, pink tablet, "xyz" marking)	Dosage:	Admin TIME(s):	Admin Location: ☐ Home ☐ School

CONSENT FOR MEDICAL TREATMENT

Subject to the conditions set forth below, I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by APTS.

Should a medical emergency arise during my child's participation in an APTS sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers listed above. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me, my child's physician, or my designated alternate, would cause, I consent to:

- The administration of medical treatment and/or surgical procedure deemed necessary by a medical doctor and/or medical facility identified above or chosen by the APTS program directors or emergency personnel; and
- The immediate administration of life-sustaining measures deemed necessary under the circumstances for the well being of my child.

To the best of my knowledge, the information in this document is complete, accurate and up-to-date.
My signature below acknowledges that I agree with the above statements and will comply with all of its requirements.

Parent or Guardian Signature: ______________________________ *Date:* ____________________________