

**ROCHESTER SCHOOL DEPARTMENT
MEDICAL AUTHORIZATION
ELEMENTARY SCHOOLS**

Grade _____
Teacher _____
Transportation: Bus # _____
Walk _____ Car _____

Student's Name _____
(Last) (First) (Middle)

Mailing Address _____ Date of Birth _____

_____ Home Tel. # _____
(City) (Zip Code)

Physical Address (if different) _____ Cell Phone # _____
Email Address: _____

Parent(s)/Guardian(s):

Name: _____ Relationship _____ Work Tel. # _____
(Last) (First) Place of Employment _____

Name: _____ Relationship _____ Work Tel. # _____
(Last) (First) Place of Employment _____

Parent student does not live with (if applicable):

Name: _____ Relationship _____ Home Tel. # _____
(Last) (First) Place of Employment _____

Mailing Address: _____ Work Tel. # _____

List **two (readily available)** people who will assume temporary care of your child if you cannot be reached:

Name: _____ Relationship _____ Tel. # _____
(Last) (First)

Name: _____ Relationship _____ Tel. # _____
(Last) (First)

Medical Information:

Name of student's physician: _____ Tel. # _____

Please list any health conditions/treatments including allergies (be specific), medications, chronic health conditions (asthma, seizures, etc.), glasses/vision concerns, hearing concerns, significant injuries etc. This information may be shared with those people who work with your child. If you have other confidential information you do not wish to list here, but may affect your child's health care, please contact your child's school nurse. _____

**** Signing this form** authorizes Frisbie Memorial Hospital to provide a free dental screening to your child. This will be done by a Registered Dental Hygienist and given to all students **grades 1-3**. This also authorizes Frisbie's Dental Program to release screening results for the purpose of follow up care to a dental professional when needed.

Check here for refusal ONLY _____ Allergy to metal ___yes___no. Allergy to Latex ___yes___no.

In case of an accident or serious illness and I cannot be reached, I hereby authorize the school personnel to secure medical help for my child.

Parent/Guardian Signature _____ Date _____

***Special circumstances** – Please attach current legal documentation/information (custody issues, history, family circumstances etc.)