EMERGENCY TREATMENT AUTHORIZATION CARD-English SCHOOL BOARD OF ORANGE COUNTY, Florida (Please Print)

Student's Legal Name:_____ School: _____ Grade:_____

Student's Date of Birth:_____ Date of last tetanus shot:_____

My child is allergic to the following medications:_____

My child has the following allergies:_____

Please identify any serious injuries or illnesses your child has had: _____

Alternate family member/friend to contact in case of emergency Name: _____

Telephone Number (s):_____

Primary Care Doctor Name:_____ Telephone Number:_____

You understand that the insurance offered by Orange County Public Schools is a secondary policy and will pay only after your personal insurance pays.

Please write "none" if you have no personal insurance on this student.

Primary Insurance Company: _____ Policy Number:_____

Insurance Company Address:_____

You understand if a parent, guardian or student falsifies any signature or information on the emergency medical treatment card, the student will be declared ineligible to participate in any Orange County interscholastic activity for one full calendar year from disclosure date. You further give your permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold the School Board and its employees harmless in the administration of such assistance. I hereby acknowledge and certify that I have read the emergency medical document, that I understand and agree with its terms. Florida Statutes (92.525) "Under penalties of perjury, I declare that I have read the foregoing and that the facts stated in it are true." I agree to be bound by its terms and I have reviewed and explained the notice with my child.

_____ _____ _____

Signature of Parent/Legal Guardian Print Name of Parent/Legal Guardian Date

Telephone (H)_____ Telephone (W)_____ Other_____

Street Address:_____ Email Address _____

City: _____ State: _____ Zip: _____

70530

TARJETA DE AUTORIZACIÓN PARA TRATAMIENTO DE EMERGENCIA-ESPAÑOL JUNTA ESCOLAR DEL CONDADO ORANGE, FLORIDA (Letra de Molde)

Nombre Legal del Estudiante: _____ Escuela: _____ Grado: _____

Fecha de Nacimiento del Estudiante: _____ Fecha de la última vacuna contra el tétano: _____

Mi hijo(a) es alérgico a las siguientes medicinas: _____

Mi hijo(a) tiene las siguientes alergias: _____

Favor de identificar cualquier lesión seria o enfermedades que su hijo(a) ha tenido: _____

Miembro de familia/Amigo alterno que pueda contactarse en caso de emergencia: _____

Nombre: _____ Números de teléfono: _____

Nombre del Médico de Cuidado Primario: _____ Teléfono: _____

Usted comprende que el seguro ofrecido por las Escuelas Públicas del Condado Orange es una póliza secundaria y pagará sólo después de que haya pagado su seguro personal.

Por favor escriba "ninguno" si no tiene seguro personal para este estudiante.

Compañía Primaria de Seguros: _____ Número de Póliza: _____

Dirección de la Compañía d e Seguros: _____

Usted comprende que si un padre, encargado o estudiante falsifica cualquier firma o información en la tarjeta para tratamiento médico de emergencia, el estudiante será declarado inelegible para participar en cualquier actividad interescolar del Condado Orange durante un año calendario completo a partir de la fecha del descubrimiento. Usted adicionalmente concede su permiso para que el personal apropiado de la escuela y sus asignados ofrezcan tratamiento médico o autorice tratamiento médico por parte de un hospital y/o médico y acepta librar a la Junta Escolar y sus empleados de responsabilidad en la administración de tal asistencia. Por la presente reconozco y certifico que he leído el documento de evaluación deportiva, que comprendo y acepto sus términos. Estatuto de Florida (92.525) "Bajo pena de perjurio, declaro que he leído lo anterior y que los hechos presentados son verídicos. Acepto estar sujeto a sus términos y he revisado y explicado la notificación a mi hijo(a).

_____ _____ _____

Firma del Padre/Madre/Encargado Legal Nombre del Padre/Madre/Encargado Legal Fecha

Teléfono (H)_____ Teléfono (O) _____ Otro: _____

Dirección: _____

Ciudad: Estado: Código Postal:

Health History

Please check all that apply and explain below. If there is a treatment, please give detailed description.

Drug Allergy (list)_____
Food Allergy (list)_____
Insect Bite Allergy (life threatening)_____
Serious injury/surgery_____
Medical Problem_____
Seizure Disorder (type)_____
Fainting (frequent)_____

Asthma___ _____
Heart Problem_____
Musculoskeletal Problem_____
Gastrointestinal Problem_____.
ADHD___ _____
Other____ _____

Current Medications_____

Details and/or Treatment Information_____ _____

Physical Activities to be restricted- include reason and details___ _____

Date of last Tetanus Shot_____ _____
Student's Physician_____Phone_____
Office Address_____ _____
Number street city state zip

I give my permission for CC band volunteers to administer the following medications to my child as indicated below. I confirm that I am the father, mother or guardian of
_____ **(Student's name)**

Initial for yes	Medication	Symptoms
	Tylenol	Mild to moderate aches/pains/headache
	Ibuprofen	Mild to moderate aches/pains/headache
	Benadryl	Allergic reactions
	Sudafed	Nasal congestion
	Tums/Mylanta	Upset stomach/antacid
	Imodium	Diarrhea
	1% Hydrocortisone cream	Contact dermatitis
	Artificial tears (saline)	Eye irritations
	Cough drops	Cough
	Cepacol	Mild sore throat
	Pepto-Bismol	Upset stomach/diarrhea
	Dramamine	Motion sickness
	Neosporin ointment	Minor cuts/abrasions

MEDICAL AUTHORIZATION

This is to authorize a hospital or physician to render emergency medical care to my son/daughter/ward_____ in the event of an emergency and I am (or other emergency
(Student's name)
contact is) unable to be reached. I grant permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic. The signature below also authorizes chaperones to administer first aid treatment as required during band functions.

_____ _____
Parent or Guardian Signature