German School of El Paso
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EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents or guardians to authorize emergency treatment to children who become ill or injured while under school authority, when parents cannot be reached. (The original form and any copies thereof may be used to identify the medical options of the undersigned parent.)

Student's Full Name: _____
Last First Middle

Student's Address: _____

Telephone No.: _____ Student's Birth Date: _____

Mother's Full Name: _____ Daytime Phone: _____

Father's Full Name: _____ Daytime Phone: _____

Alternative Emergency contact (Local people to contact if parents cannot be reached)/ Notfallkontakt:

Name: _____ Phone: _____

TO GRANT CONSENT: In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary: _____yes _____no

Doctor/s: _____Phone: _____

Hospital: _____ Phone: _____

If for any reason, the above listed parent or emergency contact cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concur to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Sollte ich/wir oder der Notfallkontakt nicht erreichbar sein, gebe ich hierbei meine Einwilligung mein Kind zu oben genannten Medizinischen Einrichtungen zu transportieren und dort notwendig erachtete Maßnahmen durchführen zu lassen.
Bei kleineren Verletzungen, z.B. Stoß-oder Schürfwunden gebe ich meine Einwilligung die Verletzung mit Kühlpaket, Pflaster und / oder Erste-Hilfe-Spray zu versorgen.

_____ja _____nein

Signature of Parent/Guardian / Unterschrift des/der Erziehungsberechtigten:

_____

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED:

Please indicate if student has had or is currently under treatment for any of the following conditions (please mark if applicable): (zutreffendes bitte ankreuzen)

- □ Asthma
- □ Diabetes
- □ Ear/Hearing Problems, Type: ___
- □ Seizures
- □ Heart Problems, Type: ___
- □ Hepatitis, Type: ___
- □ Physical Impairments: ___
- □ Meningitis
- □ Migraine Headaches
- □ Muscular Weakness Or Paralysis
- □ Bleeding Disorders, Type: ___
- □ High Blood Pressure
- □ Infectious Diseases, Type: ___
- □ Tetanus Shot: (date) ___
- □ Other: _____

Allergies/Allergien: □ no □ yes _____

Long Term Medications/Dauermedizin: □ no □ yes, _____

Reactions to Medicine or Injections/ allergische Reaktionen auf Medikamente oder Injektionen:

□ no □ yes, _____

Hospitalized for Serious Illness, Surgery or Accident / längerfriste Krankenhausaufenthalte:

□ no □ yes, _____