Texarkana Independent School District
Health Information and Emergency Care Authorization

Student Name _____
Last First Middle
Birthdate_____ Grade_____ Sex _____ ID#_____
Address _____

_____ _____ _____
Father's Name Work # Cell Phone/Pager
Email _____

_____ _____ _____
Mother's Name Work # Cell Phone/Pager
Email _____

_____ _____ _____
Alternate Adult Work # Cell Phone/Pager
Email _____

Please complete important information on entire card.

IMPORTANT MEDICAL INFORMATION

❑ My child has no known medical problems.
❑ My child has the following medical problems: _____

_____

_____

List any medication(s) your child takes on a routine basis: _____

_____

_____

Does your student have allergic reactions to any drug, food or insect bites? ❑ Yes ❑ No
If yes,:
Name of drug: _____
Name of food(s): _____
Name of insect: _____
Is the allergic reaction considered life threatening? ❑ Yes ❑ No
What is a typical reaction and treatment? _____

_____

_____ _____
Signature of Parent or Guardian Date

FAMILY PHYSICIAN

Name: _____ Phone #: _____

HOSPITAL

Name: _____ Phone #: _____

HEALTH INSURANCE

My child is covered by: ❑ Medicaid ❑ CHIP ❑ No Insurance ❑ Insurance

EMERGENCY MEDICAL TREATMENT

In the event of a medical emergency at school, the school will first try to contact the child's parent. If the parent cannot be reached, and the child needs immediate medical treatment, the information below would be given to the hospital or clinic. The purpose of the Emergency Medical Treatment Form is to obtain medical treatment for your child in the event you cannot be contacted. The school does not assume any financial responsibility, but does wish to provide the best service possible in an emergency.

Please complete the following information below.

I hereby authorize **Texarkana Independent School District** to consent to emergency medical treatment for:

_____ _____

Student's First/Last Name (Printed) Grade

I understand in granting this authorization that:

- My child will be taken to a hospital or clinic nearest to the school or activity he or she is attending so that emergency medical treatment can be obtained.
- School staff members will attempt to contact me before consenting to emergency medical treatment of my child and for the transportation to the emergency medical treatment facility.
- I release TISD staff members and trustees from any and all claims or actions from liabilities for the injuries that occur to my child as a result of his or her receipt of emergency medical care.
- The staff members of the TISD, its trustees and agents are not waiving sovereign or governmental immunity by requesting the execution of this document.
- I understand the provisions of this document and execute it voluntarily.
- I give my permission to TISD staff to release health information pertaining to my child to other health care professionals involved with my child.

_____ _____ _____

Signature of Parent or Guardian Home & Work Phone Date