CENTER FOR SPECTRUM SERVICES
Brightening the lives of people with autism

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CONSENT FOR EMERGENCY MEDICAL/SURGICAL TREATMENT

Student:_____(Nickname):_____D.O.B:_____

Parent or Legal Guardian _____

Street Address_____

Mailing Address (if different):_____

Mother's Home Phone #:_____ Father's Home Phone #:_____

Mother's Work #:_____Father's work #:_____

Mother's Cell #:_____ Father's Cell #:_____

Mother's E-mail: _____ Father's E-mail: _____

Mother's Occupation/ Place of Employment:_____

Father's Occupation/Place of Employment:_____

Medicaid Number:_____ Health Insurance Number: _____

Daycare Provider:_____Phone:_____

Street Address:_____ Days/Times:_____

EMERGENCY CONTACT INFORMATION: Please provide at least 2 names:
In the event my child becomes ill and I cannot be reached, I authorize the following people to be called and pick up my child from school. If this contact list changes, I will immediately notify the school.

Name_____Relationship_____Daytime phone #:_____

Name:_____Relationship:_____Daytime phone #:_____

Contact Restrictions: Does child have an Order of Protection or are there legal restrictions prohibiting contact against anyone? Yes_____ No_____ If yes, who:_____

I hereby give permission and voluntarily consent to any of the Emergency Room physicians, qualified personnel, or staff of a duly licensed hospital, or any duly licensed physician or dentist in the State of New York to administer anesthetics and perform such diagnostic treatment or medical or operative procedures, including transfusions, upon my listed child, as may be deemed necessary.

_____ _____

Parent/Guardian signature **Date**

IT IS NECESSARY THAT THIS INFORMATION BE CURRENT.
PLEASE INFORM CENTER FOR SPECTRUM SERVICES OF ANY CHANGES DURING THE SCHOOL YEAR.
2016/17 School Year

MEDICAL / ELOPEMENT ALERT INFORMATION

Student Name _____ Date of Birth_____Sex:_____

Height_____Weight_____Hair Color_____Eye Color_____Glasses_____Hearing Aides_____
Does child wear: _____ID card ____Medical Alert Tag ____Tracking Device ____Other
Identifying marks/scars_____

Medical Diagnosis _____

Primary Care Physician_____
Address_____Phone_____

Other Medical Specialists _____
Address_____Phone_____

My child takes the following medications on a routine basis

Medication	Dose	Times given	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child exhibited any of the following (please check all that apply)
___ Date of last Tetanus vaccine_____
___ History of seizure activity:
Type_____ Frequency_____
Treatment_____
Is child currently seizure active? _____Last known seizure _____
____Significant allergies
Food allergies requiring special diet_____Food sensitivities_____
Medication allergies_____Environmental _____
Other _____
____ Asthma or chronic upper respiratory difficulties

Important information

___no sense of danger	____hearing impaired	___vision impaired
___communication delay	____ non-verbal	___poor response to language
___does not respond to name	____does not respond to inhibitory words (no, stop, come here)	
___uses a communication device	____ sensory concerns	___significant fears

____Favorite toys, objects, music, topics of iscussion:_____
___other important information _____
_____

Has the child wandered off before? _____ Places the individual may wander to_____
water sources_____
friends /neighbors_____
hiding spots_____
other_____
Unusual behaviors or characteristics that may attract attention _____
Additional Information: _____
_____

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