**Hamilton Central School**
47 W. Kendrick Ave, Hamilton NY, 315-824-6300

# Medical Information & Medical Treatment Authorization

Child's Name _____ Grade _____

**Does your child have any of the following conditions?**

Asthma: Yes _____ No _____ If yes, any Medications? _____

Diabetes: Yes _____ No _____ If yes, any Medications? _____

Seizures: Yes _____ No _____ If yes, any Medications? _____

Other: _____ If yes, any Medications? _____

**Allergies:**

Medication: Yes _____ No _____ Type: _____ Reaction: _____

Food: Yes _____ No _____ Type: _____ Reaction: _____

Other Allergies: _____ Reaction: _____

**Current Treatment:**

Is your child receiving treatment for ANY conditions: Yes _____ No _____

If yes, for what condition? _____

What is the Treatment? _____

Will our child need to take any medication during the school day? Yes _____ No _____

**If yes, you will need to fill out an "Authorization for Administration of Medication at School" form.**

**Medical Treatment Authorization:**

I, being the parent/ legal guardian of the above mentioned child, do hereby authorize Hamilton CSD faculty members to act in my behalf in authorizing unexpected medical treatment for the above named child, during the 20_____ school year. I expect that efforts will be made to contact me (or other guardian) at the numbers below, before treatment is to be under taken.

Parent/Guardian Name (Please Print): _____ Date: _____

Parent/Guardian Signature: _____

**Emergency Contact Information:**

Contact 1 (Please Print): _____ Phone: _____

Contact 2 (Please Print): _____ Phone: _____

Contact 3 (Please Print): _____ Phone: _____