Louis A. Johnson VA Medical Center
Minor Child Parent/Guardian Authorization
For Pre-Employment (Volunteer) Physicals,
Emergency Medical Treatment and Immunization's
(Parent/Guardian, Please fill out form completely and sign)

I, _____, the natural parent (or legal guardian) hereby gives

permission that my child, _____
STUDENTS NAME (LAST) (FIRST)

Soc. Security # _____ Date of Birth _____

_____

Street Address **City** **Zip**

_____ _____

Area Code & Home Phone Number **Area Code & Cell Phone Number (if applicable)**

- May receive a Pre-Employment physical if required for position applying for (which would include lab draw, vitals, eye exam, hearing test, and non invasive exam by provider).
- May be given emergency treatment to include first aid and CPR by qualified staff at the internship site. I authorize and consent to medical, surgical and hospital care. Treatment and procedures may be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
- I further give permission for my son/daughter to receive a baseline tuberculin skin test (tbt) (PPD).
  - If my son/daughter has a history of a Positive PPD, I further give permission for my son/daughter to have blood drawn for TB testing and/or chest x-ray.
- I further give permission for my son/daughter to be followed by the hospital's policy/protocol for any incident that is related to a Blood Borne Pathogen Exposure.

The following information will be used for obtaining emergency medical treatment in case of injury or illness during training. Please make sure to fill out completely.

_____

Parent/Guardian/Adult to Contact in Case of Emergency **Relationship to Student**

_____

Street Address **City** **Zip**

_____ _____

Area Code & Home Phone Number | Area Code & Cell Phone Number |Area Code & Work Phone Number

_____

***Alternate Adult in Case Person Above cannot be Reached** **Relationship to Student**

_____

Area Code & Home Phone Number | Area Code & Cell Phone Number |Area Code & Work Phone Number

Students Personal Family Doctor: _____ Phone: _____

Doctor's Address _____

Hospital Preference _____

- **Has your son/daughter ever suffered from any of the following: (Please check all that apply)**

Asthma_____ Epilepsy_____ TB_____ Diabetes_____ Sight Impaired_____ Back Problems_____

Hernia_____ Heart Disease_____ Hearing-Impaired_____ Stomach Disorder_____ Diabetes_____

High Blood Pressure_____ Low Blood Pressure_____ Hypoglycemia_____ None_____Other _____
(Specify)

- **Does your son/daughter have allergies (this includes any allergies to Medications)YES [ ] NO [ ]**
  - **If YES, Please list all allergies and reaction's**

Type of Allergy	Type of Reaction

- **Is your son/daughter currently taking any medication? Yes [ ] No [ ]**

  If YES, please list _____

- **Has your son/daughter ever received a BCG inoculation? (This is a common vaccination that they might have received as a child if born in a foreign country). Yes [ ] No [ ]**

- **Has your son/daughter ever had a positive (red and raised injection site) TB test? Yes [ ] No [ ] (This is a test for TB)**

- **Has your son/daughter ever had a allergic reaction to the TB test Yes [ ] No [ ]**

- **Is the student listed on this form currently pregnant? Yes [ ] No [ ]**
  If YES, please give due date _____

- **Does your son/daughter have any physical condition that would prevent him/her from doing certain types of work? Yes [ ] No [ ]**
  If YES, please explain _____

- **Does your son/daughter have any mental condition that would prevent him/her from doing certain types of work? Yes [ ] No [ ]**
  If YES, please explain _____

- **Approximate date of your son's/daughter's last Tetanus shot: _____**

- **Please indicate whether your son/daughter may receive the annual FLU SHOT: Yes [ ] No [ ]**

- **In case of medical treatment, all medical related to treatment maybe released to Doctor listed on front of form and the student's school nurse.**

_____

PARENT/GUARDIAN SIGNATURE* DATE**

***** This signature authorizes emergency medical treatment, immunizations, PPD, lab work, x-rays and pre-employment physicals.**

This document is scanned into permanent CPRS record.