EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name: _____

Address: _____

City/Zip Code: _____

Student lives with:_____

Grade: _____

Birthdate: _____

Home Phone Number: _____

☐ **Please check box if your address or phone number has changed since last school year.**

☐ **Please check box if any court or custody papers are applicable for this student.**

PARENT/GUARDIAN(S) AND EMERGENCY CONTACTS

Call Order:	Relationship:	Name:	Day Phone:	Cell Phone:	Email:	Can Pick Up:
_____	_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	_____	____

***Cell phone number you would like on "Remind" app for important text messages throughout the year:* _____

Please indicate if your child has any of the following:

1) Allergies (please list): _____
2) Medications* (please list): _____
3) Inhalers* (please list): _____
4) Other medical concerns or conditions to which medical personnel should be alerted?

_____

**** Use and/or possession of any medications, whether prescribed or not, requires the appropriate documentation to be completed and on file with the school.***

PART I *OR* PART II *MUST BE COMPLETED*

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

		Office Phone:	Address:
Physician:	_____	_____	_____
Dentist:	_____	_____	_____
Medical Specialist:	_____	_____	
Local Hospital:	_____	_____	

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the appropriate medical professional; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Signature of Parent/Guardian for Grant to Consent **Date**

PART II: REFUSAL TO CONSENT

I do <u>NOT</u> give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____ _____

Signature of Parent/Guardian for Refusal to Consent **Date**