Windham Exempted School District
Emergency Medical Authorization Form

Student Name: ________________________________________ Date of Birth: ________________________

Address: ________________________________________ Phone: ________________________

School: ________________________________________ Grade: __________ Bus No. __________

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Mother: __________________________ Home #: __________________Work #:__________________ Cell #:__________________

Father: __________________________ Home #: __________________Work #:__________________ Cell #:__________________

Guardian: __________________________ Home #: __________________Work #:__________________ Cell #:__________________

Stepparent: __________________________ Home #: __________________Work #:__________________ Cell #:__________________

If my child becomes ill and attempts to contact me have been unsuccessful, I authorize the school to call the following persons who are authorized to pick up my child.

Name : ____________________________ Relationship: _____________________________ Phone #:______________________

Name : ____________________________ Relationship: _____________________________ Phone #:______________________

Name : ____________________________ Relationship: _____________________________ Phone #:______________________

<u>**Part I or II Must Be Completed**</u>

**PART I: TO GRANT CONSENT**

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

Doctor: ______________________________ Phone #: ________________________

Dentist: ______________________________ Phone #________________________

Preferred Hospital: ______________________________

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessibly. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment(s) to which a physician should be alerted:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Date: ____________________ Signature of Parent/Guardian: ______________________________________________

**PART II: REFUSAL TO CONSENT**

I do NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school authorities to take the following action(s):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Date: ____________________ Signature of Parent/Guardian: ______________________________________________

**Student Information Sheet**

Student Name: ________________________________________ Date of Birth: ________________________

Student's Place of Birth: ________________________

Father's Name (living in home): ________________________________

Mother's Name (living in home): ________________________________

Address: _________________________________________________________

Home Phone #: ________________________ Cell #: ________________________

Mother Work Place:________________________ Work #: ________________________

Father Work Place: ________________________ Work #: ________________________

If student is NOT residing with natural parents, with whom does the student reside: ________________________________

List the person(s) names and phone numbers who have your permission to assume temporary care of the student (i.e. take students out of school, student may go home to, pick student up for appointments, student engage in conversation, etc.)

________________________________________________________________________________________________________

________________________________________________________________________________________________________

**Special Instructions:** Are there any person(s) the school needs to be aware of relative to the release and safety of the student? (Example: Ex-spouse- do they have the right to see, speak to, remove child from school, etc.) conversation, etc.)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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