

Emergency Medical Authorization

Student Name _____ Date of Birth _____

Address _____ Home Phone _____

School _____ Grade _____ Homeroom _____ 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.

Mother _____ Home # _____ Work # _____ Cell # _____

Father _____ Home # _____ Work # _____ Cell # _____

Stepparent _____ Home # _____ Work # _____ Cell # _____

Guardian _____ Home # _____ Work # _____ Cell # _____

If my child becomes ill at school 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 _____

PART I OR 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:

Doctor _____ Phone _____ Dentist _____ Phone _____

Preferred 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 above named doctor, or, in the event of the designated preferred practitioner is not available, by another licensed physician or dentist 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.

Facts concerning the child’s medical history including allergies, medications being taken and any physical impairments 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 illness or injury requiring emergency treatment I wish the school authorities to take the following action:

Date _____ Signature of Parent/Guardian _____

Student Information

Student Name _____
Last First Middle

Date of Birth _____ Place of Birth _____
Month/Day/Year City State County

Address _____ P.O. Box _____

Father's Name _____ Living in the home? Yes No

Mother's Name _____ Living in the home? Yes No

Home Phone _____

Mother's Cell Phone _____ Mother's Work Phone _____

Father's Cell Phone _____ Father's Work Phone _____

If the student is not residing with the natural parents, with whom does the student reside?

List the names and phone numbers of individuals who have your permission to assume temporary care of the student (i.e. take student out of school, may go home with, pick up for appointments, have phone or office visits with and or engage in conversations with?)

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Special instructions we need to be aware of concerning the release and safety of your student?
(Example: Does an ex-spouse have the right to see, speak to, remove student from school, etc.?)

