



EMERGENCY MEDICAL AUTHORIZATION

Date of Birth _____

Student: _____
(Last) (First) (Middle)

Class: _____

Address: _____
(Street, City, State, Zip)

Home Phone: _____

Mother's Name: _____

Work Phone: _____

Father's Name: _____

Work Phone: _____

Cell Phone or Pager Numbers: Father _____

Mother _____

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know.

Purpose: To enable parents or guardians to authorize emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Part One or Two Must be Completed

PART ONE: TO GRANT CONSENT

In the event reasonable attempts to contact me at home or at work or other parent or guardian have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:

Dr. _____ (preferred physician) Phone: _____

Dr. _____ (preferred physician) Phone: _____

or, in the event the DESIGNATED preferred practitioner is not available, by another physician or dentist: and

2. The transfer of the child to _____ (preferred hospital) Phone: _____
or any other 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. A school official will accompany the child until a parent or guardian can be reached.

Signature of Parent or Guardian: _____ Address: _____ Date: _____

Do NOT complete Part Two if you have completed Part One.

PART TWO: 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 school authorities to TAKE NO ACTION OR TO _____

Signature of Parent or Guardian: _____ Address: _____ Date: _____

Please complete both sides of this form.

Child's Name _____ Date of Birth _____

Height _____ Weight _____

CHRONIC PHYSICAL PROBLEM(S):
HISTORY OF HOSPITALIZATION:
DISEASES THIS CHILD HAS HAD:
ALLERGIES AND TREATMENT:
MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLOURIDE SUPPLEMENTS:

List of person(s) to whom this child can be released: (Please print)

List of person(s) not permitted to pick up this child: (Please print)

	Restraint papers or divorce decree attached	
	Yes	No

IMPORTANT: Please attach a copy of your child's immunization records

EXEMPT FROM IMMUNIZATIONS	Please mark	
	Yes	No
Religious conviction		
Other:		

Parent/Guardian signature for immunization exemption:



EMERGENCY MEDICAL FORM TRANSPORTATION ADDENDUM

Child's Name: _____

Homeroom: _____

Please check the normal way your child will be transported to and from school.

_____ Bus District _____ Bus # AM _____ Bus # PM _____

_____ Car Rider AM _____ PM _____

Daily changes from the normal dismissal plans need to be communicated in writing to the teacher on the morning of the change. If your schedule changes weekly, please send in a weekly schedule to your child's teacher at the beginning of the week.

The following persons have the authority to pick up my child from school in the case of an early dismissal, an evacuation, or other emergency. The school assumes that parents will communicate with the people listed on the forms about their wishes. Fill in as many spaces as you deem fit. Having this information in advance will facilitate the smooth handling of any mass unscheduled pick-up from school.

In the event of an emergency, and if I cannot pick up my child, he/she may leave school with the following people. Be sure to include the name of an older sibling if applicable. Information should be completed for EACH person a parent wishes to authorize. The authorized person will be asked to sign out your child and show drivers' license if not recognized by the office staff.

1. Name of adult authorized to pick up my child: _____.

Phone Number of authorized adult: _____

2. Name of adult authorized to pick up my child _____.

Phone Number of authorized adult: _____

3. Name of adult authorized to pick up my child: _____.

Phone Number of authorized adult: _____

4. Name of adult authorized to pick up my child: _____.

Phone Number of authorized adult: _____