

New emergency medical forms are required each school year. Please carefully review the printed information. Make changes, corrections or additions as needed. Sign under Part I or Part II to indicate that you give or do not give consent for emergency medical treatment of your child.

EMERGENCY MEDICAL AUTHORIZATION FOR ALL SCHOOL RELATED ACTIVITIES

STUDENT NAME: _____ DOB: _____ SCHOOL: _____

ADDRESS: _____, _____, _____ GRADE: _____ ID# _____

TELEPHONE: _____ UNLISTED: _____ TEACHER: _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, and to authorize a person to whom the school may release a child to, when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Name	Home	Cell	Work	Ext	Type

EMERGENCY CONTACT OTHER THAN PARENT TO WHOM MY CHILD MAY BE RELEASED IN THE CASE OF A MEDICAL OR OTHER EMERGENCY:

Name	Home	Cell	Work	Ext	Type

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT:

DOCTOR TO BE CALLED: _____ PHONE: _____

DENTIST TO BE CALLED: _____ PHONE: _____

MEDICAL SPECIALIST: _____ PHONE: _____

HEALTH INSURANCE COMPANY: _____

POLICY NUMBER: _____ EMPLOYER PROVIDING: _____

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 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.

Preferred local hospital: _____

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.

Please check any boxes below indicating anything that we need to be aware of concerning your child:

<input type="checkbox"/> Asthma : Triggers _____ Inhaler Y__ N__	<input type="checkbox"/> Medications: _____
<input type="checkbox"/> Food Allergies: To What _____ EPI Pen Y__ N__	<input type="checkbox"/> Other Health Conditions: _____
<input type="checkbox"/> Insect Allergies: To What _____ EPI Pen Y__ N__	_____
<input type="checkbox"/> Other Allergies: To What _____ EPI Pen Y__ N__	<input type="checkbox"/> Diabetes
Additional Information: _____	<input type="checkbox"/> Heart Condition
_____	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Vision Problems
_____	<input type="checkbox"/> Hearing Problems
_____	<input type="checkbox"/> Eating Problems

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Date: _____ Signature of parent/guardian: _____

Address: _____

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 no action or to:

Date: _____ Signature of parent/guardian: _____

Address: _____