

## Emergency Medical Authorization Form

STUDENT NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY/ZIP CODE: \_\_\_\_\_ / \_\_\_\_\_

HOME PHONE : \_\_\_\_\_  
 BIRTH DATE: \_\_\_\_\_  
 GRADE: \_\_\_\_\_

### PARENTS OR GUARDIANS

Mother's Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Zip Code : \_\_\_\_\_ / \_\_\_\_\_  
 Place of Employment \_\_\_\_\_

E-Mail: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

Father's Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Zip Code : \_\_\_\_\_ / \_\_\_\_\_  
 Place of Employment \_\_\_\_\_

E-Mail: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

**CUSTODIAL PARENT: (circle one)    MARRIED                      JOINT                      MOTHER                      FATHER**

Military Parent: (If applies, circle one or more)    ACTIVE DUTY    NAT. GUARD    DISCHARGED

### OTHER PARENTS OR GUARDIANS WITH AUTHORIZATION TO CONSENT FOR CARE

Stepmother's Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Zip Code : \_\_\_\_\_ / \_\_\_\_\_  
 Place of Employment \_\_\_\_\_

E-Mail: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

Stepfather's Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Zip Code : \_\_\_\_\_ / \_\_\_\_\_  
 Place of Employment \_\_\_\_\_

E-Mail: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

**You must complete either PART I or PART II below. Purpose: to enable parents and/or 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. This side will be used during school hours and for authorized school activities including field trips.**

Part I: TO GRANT CONSENT: 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 following health care providers, or if the designated preferred practitioner is not available, by another licensed healthcare provider or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Primary Care Physician: \_\_\_\_\_  
 Dentist: \_\_\_\_\_  
 Medical Specialist: \_\_\_\_\_  
 Local Hospital: \_\_\_\_\_

Telephone: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

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. The following are facts concerning the child's medical history, including allergies, medications being taken and any physical impairments or chronic conditions to which a physician should be alerted include:

\_\_\_\_\_  
 Signature or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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;

\_\_\_\_\_  
 Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

### TELEPHONE CALLING ORDER

During the course of the school year there are times when a student may need to leave school due to illness or communicable disease requiring transportation home. Parents or guardians may not be available during these times. Students who are ill must be dismissed to a responsible adult. Please list below the names of five adults (including yourself as parent/guardian) who you would prefer for us to call in case of an illness or emergency. **Please put these names in the order of who should be called first, second, etc.** Please notify the school when telephone numbers change.

	Name	Relationship to Student	Phone: Home, Work, Cell
1.	_____	_____	-(____)_____
2.	_____	_____	-(____)_____
3.	_____	_____	-(____)_____
4.	_____	_____	-(____)_____
5.	_____	_____	-(____)_____

In order to help us plan for a safe and healthy school experience for your child, please check and give details of the any of the following that currently apply to this student:

- \_\_\_ Asthma \_\_\_\_\_
- \_\_\_ Bleeding Disorder \_\_\_\_\_
- \_\_\_ Depression \_\_\_\_\_
- \_\_\_ Diabetes \_\_\_\_\_
- \_\_\_ Cancer \_\_\_\_\_
- \_\_\_ Eating Disorder, anorexia, bulimia, obesity \_\_\_\_\_
- \_\_\_ Epilepsy \_\_\_\_\_
- \_\_\_ Has a cast, brace, wheelchair or other supportive or assistive device \_\_\_\_\_
- \_\_\_ Heart Condition \_\_\_\_\_
- \_\_\_ Life threatening allergies (anaphylaxis) \_\_\_\_\_
- \_\_\_ Food or other allergies (non life threatening) \_\_\_\_\_
- \_\_\_ Medication during the school day \_\_\_\_\_
- \_\_\_ Mental health concerns \_\_\_\_\_
- \_\_\_ Pregnancy \_\_\_\_\_
- \_\_\_ Shunt \_\_\_\_\_
- \_\_\_ Smoking \_\_\_\_\_
- \_\_\_ Wears a hearing aid or is deaf \_\_\_\_\_
- \_\_\_ Wears corrective lenses (glasses or contacts) \_\_\_\_\_
- \_\_\_ Wears prosthesis \_\_\_\_\_

\_\_\_ My child has special health care needs. Please have the school nurse contact me to develop a school based health plan.

The space below is provided for you to list any additional information concerning your child's health or medical conditions of which the school staff should be aware \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Yes  No  I give permission to share this health information with school staff as needed.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_