

EMERGENCY MEDICAL AUTHORIZATION

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.

Student's Name: _____ Birthdate: _____ Grade: _____

Home Address: _____ Teacher/Homeroom _____

City/State/Zip: _____ Date of last Tetanus: _____

Student resides with (circle all that apply) Mother Father Stepparent Guardian County of Residence _____
List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e. 1st, 2nd):
(The school will only contact the names listed below in the event of sickness or injury)

____ Mother: _____ Home # _____ Work# _____

____ Father: _____ Home # _____ Work# _____

____ Stepparent: _____ Home # _____ Work# _____

____ Guardian: _____ Home # _____ Work# _____

____ Relative or alternate (i.e., child care provider), if applicable: Relationship to Child: _____
Name: _____ Home # _____ Work# _____

Medical History: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

COMPLETE ONLY ONE OF THE FOLLOWING: I. Consent for Treatment OR
II. Refusal to Consent

<p>I. CONSENT FOR TREATMENT: I hereby give consent for the following medical care providers and local hospital to be called:</p> <p>Preferred Physician: _____ Office# : _____</p> <p>Preferred Dentist: _____ Office#: _____</p> <p>Medical Specialist: _____ Office#: _____</p> <p>Preferred Hospital: _____ ER#: _____</p> <p style="text-align: center;">AND</p>	<p>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:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Parent/Guardian Signature _____ Address: _____ Date: _____</p>
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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 preferred doctor indicated, 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.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature: _____ Date _____
(Please complete both sides of form)

STUDENT/PARENT INFORMATION SHEET

Student Name _____
Last First Middle

STUDENT HANDBOOK

_____ My parent/guardian and I have read the Student Handbook.

PICTURE PUBLICATION

Pictures are used throughout the year for publication through newspaper and e-mail. Please mark below according to your wishes.

_____ Permission is given for our child's picture to be published.

_____ Please do not publish our child's picture.

EMERGENCY SCHOOL CLOSING

Please DO NOT call the school when severe weather or other emergencies are threatening. Phones must be open for emergency calls only.

My child is to:

_____ ride his/her regular bus home.

_____ ride bus number _____ to _____

Name

Phone

Address

_____ be picked up by _____

SIBLINGS

Name of brothers

Age

Name of sisters

Age

I understand all the above information and have no questions at this time.

Name of Parent/Guardian

Date

E-mail Address