PLEASE only list names of the people that are **allowed** to pick your child up in the event of illness, emergency, etc.

EMERGENCY MEDICAL AUTHORIZATION

_____The school has custody papers on file for my child

Student Name | **Grade** | **Gender**

Student Home Address | **Parent E-Mail Address**

City, State, Zip | **Student Birth Date**

Mother's Name | **Mother's Address (if different)** | **Mother's Cell Phone Number**

Father's Name | **Father's Address (if different)** | **Father's Cell Phone Number**

Guardian(s) (if applicable) | **Daytime Phone Number**

***Name of Relative or Friend allowed to pick up child if ill or emergency** | **Relationship to child** | **Daytime Phone Number**

***Does the student have a parent in the military (Circle One):** **No** **Active Duty** **National Guard (Army or Air)**

***Purpose – To enable parents and guardians to authorize the provision of emergency treatment for child who becomes ill or injured while under school authority, when parents or guardians cannot be reached.**

Doctor's Name_____ **Phone**_____

Dentist's Name_____ **Phone**_____

Medical Specialist's Name_____ **Phone**_____

Local Hospital Preferred_____ **Phone**_____

PART 1 OR PART 2 MUST BE COMPLETED

PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me, the other parent, or guardian, have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the listed doctor, dentist, or medical specialist, or, in the event the designated preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer of the child to the above hospital or 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 or mental impairments to which a physician should be alerted:

_____

_____

SIGNATURE OF PARENT OR GUARDIAN | **DATE**

PART 2 – REFUSAL TO CONSENT (Do not complete part 2 if you completed part 1)

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**