New emergency medical forms are required each school year. 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#: _____

PHONE: _____ UNLI STED: _____ 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 the school may release a child to, when parents or guardians cannot be reached.

PARENT OR GUARDIAN:

Name	Home Phone	Cell Phone	Work Phone Ext

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

Name	Home Phone	Cell Phone	Work Phone Ext

Will your child ride the bus to and from school? No: _____ Yes: _____

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: _____

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 that we need to be aware of concerning your child:

☐ Asthma: Triggers: _____
Inhaler: Y _____ N _____

☐ Food Allergies: To What: _____
EPI Pen: Y _____ N _____

☐ Insect Allergies: To What: _____
EPI Pen: Y _____ N _____

☐ Medications: _____
_____

☐ Other Health Conditions: _____
_____

☐ Diabetes ☐ Seizures ☐ Hearing Problems
☐ Heart Condition ☐ Vision Problems ☐ Eating Problems

Additional Information: _____
_____

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: _____

*** If the student has a medical condition such as allergies, severe asthma, diabetes, heart problems, seizures, an individual student health plan will need to be completed each school year. This health plan will need to be shared with the student's teachers and other school staff for the safety of the student while at school.**

**** Student requiring medication (prescription and non-prescription) at school MUST have a written physician order and written parental consent. These forms are available in the school health office and on the school and district website. A new form must be completed each school year. Medications must be brought to the school health office by the parent/guardian, not the student.**