Hardy Elmore School District

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE of this form:

To authorize the provision of emergency medical treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Please **PRINT** relevant information.

STUDENT NAME _____

SOC SEC # _____ **GRADE** _____

HOME ADDRESS _____

HOME PHONE (____) _____ **DATE OF BIRTH** _____

PRIMARY E-MAIL ADDRESS _____

PLEASE INDICATE IF THERE ARE ANY CHANGES IN THE ABOVE INFORMATION FROM THE PREVIOUS SCHOOL YEAR ☐ **YES** ☐ **NO**

RESIDENTIAL PARENT OR GUARDIAN:
If custodial parent, please check box.

☐ Mother's Name _____

Home Phone (____) _____ Cell Phone (____) _____
(If different from above)

Work Phone (____) _____ Pager No. (____) _____

☐ Father's Name _____

Home Phone (____) _____ Cell Phone (____) _____
(If different from above)

Work Phone (____) _____ Pager No. (____) _____

Guardian's Name _____

Home Phone (____) _____ Cell Phone (____) _____
(If different from above)

Work Phone (____) _____ Pager No. (____) _____

PLEASE COMPLETE PART I OR PART II BELOW

PART I - TO GRANT CONSENT

hereby give consent for the following medical care providers and local hospital to be called in an emergency:

Physician _____ Phone (____) _____

Dentist _____ Phone (____) _____

Medical Specialist _____ Phone (____) _____

Hospital _____ Phone (____) _____

In the event that reasonable attempts to contact me have been unsuccessful, I grant my consent for:

(1) The administration of any treatment deemed necessary by above-named physician, or, in the event the designated preferred practitioner is not available, by another licensed medical practioner; and

(2) The transfer of the child to any reasonable accessible hospital.

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

Please indicate any facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: _____

_____

SIGNATURE OF PARENT _____ ADDRESS _____ DATE

PART II - REFUSAL TO CONSENT (do not complete Part II if you completed Part I)

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 authoritites to take no action or to: _____

_____

_____
SIGNATURE OF PARENT

_____
Address

(SEE REVERSE SIDE)

PERSONAL SCHOOL INFORMATION FORM

PLEASE PRINT ALL INFORMATION

NAME _____ GRADE _____

FATHER'S NAME _____

FATHER'S EMPLOYER _____

BUSINESS PHONE _____

MOTHER'S NAME _____

MOTHER'S EMPLOYER _____

BUSINESS PHONE _____

I give permission for the individuals/child care provider listed below to assume temporary care of my child if parent/guardian cannot be reached:

1. Name _____

   Address _____ Phone _____

   Relationship _____

2. Name _____

   Address _____ Phone _____

   Relationship _____

_____ _____

Signature of Parent/Guardian Date