

Emergency Medical Authorization

Student LEGAL First Name	LEGAL Middle Name	LEGAL Last Name
Street Address		P.O. Box
City	Zip	County
Home Phone Number ()		
Date of Birth	Grade	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
MOTHER		FATHER
Name		Name
Cell Phone ()		Cell Phone ()
Business Phone ()		Business Phone ()
Daytime Phone ()		Daytime Phone ()
Marital Status – The student’s parents are: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Student resides with _____ <input type="checkbox"/> If parents are divorced, please check here for permission to contact the student’s non-custodial parent in case of illness, injury or emergency. <i>It is the responsibility of the parent to provide current information regarding any court orders that are on file for the student.</i> Name of Non-Custodial Parent: _____ Phone Number () _____		
Please list alternate person(s) to contact in case neither parent can be reached:		
Name		Name
Relationship		Relationship
Address		Address
Phone Number ()		Phone Number ()
Cell Phone Number ()		Cell Phone Number ()

Preferred Physician: _____ Phone: _____
 Preferred Dentist: _____ Phone: _____
 Preferred Hospital: _____ Phone: _____

Medical Consent – If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage the school personnel and said physician/dentist to exercise their best judgment as to the requirement of such diagnosis or treatment.

It is also understood that every possible attempt will be made to contact the parents first; only in case of extreme emergency and failure to be able to contact the parents will this apply. It is further warranted that if this consent form is signed by one of two parents or guardians, it is with the authority of the other.

Child’s Medical History – Facts concerning the child’s medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: _____ Medications: _____
 Physical Impairments: _____ Other Pertinent Information: _____
 Date of last tetanus shot: _____

***** It is the responsibility of the parents to keep the school informed of any changes in contact or medical information *****

I hereby give consent for the medical care providers and local hospital listed above to be called.

▼ Signature of Parent /Guardian ▼

Date: _____