EMERGENCY MEDICAL AUTHORIZATION

SCHOOL _____

STUDENT INFORMATION:

Student Name: _____ Date of Birth _____
Last First

Grade: _____ Teacher/Team _____

Mother: _____ Phone #: _____ Work #: _____

Father: _____ Phone #: _____ Work #: _____

Is there a legal custody order that applies to this child Yes or No

If yes, give details: _____

EMERGENCY CONTACTS: *(if parent or guardian cannot be reached):*

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

EMERGENCY CARE INFORMATION:

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred Hospital: _____ Location: _____ Phone: _____

Allergies and/or Specific Health Considerations: _____

Medications taken by student on a daily or frequent basis: _____

Food Intolerance (does **NOT** require immediate medical attention): _____

Food Allergy (**requires immediate** medical attention):_____

Other: _____

CONSENT

In the event attempts to contact me have been unsuccessful, I give my consent for any treatment deemed necessary by the physician or dentist in charge, and also for the transfer of the child to the hospital most reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists are obtained in concurrence. In addition, I hereby, for myself and my child, waive and release any and all rights and claims for damages I or my child may have against the Eastern Local Schools, its employees, contractors, volunteers or representatives, for any and all injuries suffered by myself or my child in any activity sponsored by this group. I furthermore indemnify and save harmless the Eastern Local Schools for any and all loss and damage to person or property that may arise out of participation in this activity.

In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all school personnel that interact with my child.

PARENT/GUARDIAN SIGNATURE: _____ ***DATE:*** _____

Student Signature (if 18 yrs. of age or older): _____ Date: _____

Medical Insurance Provider _____ Policy # _____

REFUSAL TO CONSENT

(Complete only if action described above is refused)

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: (please explain) _____

PARENT/GUARDIAN SIGNATURE _____ ***DATE:*** _____