THE BRIDGE PROGRAM – EMERGENCY MEDICAL FORM 2026-2027

Student Name:	**Home No.**	**Cell No.**	
Address:	**City:**	**State:**	**Zip:**
Date of Birth:	**Gender:**		

Living with *(check one)* _____Both parents _____Mother only _____Father only
_____Other *(please explain)*_____

Father's Name_____**Mother's Name:**_____

Guardian Name *(if different from above)*:_____

Number of children in family under school age_____*(please list children of school age below)*

Name:	**Grade:**	**Name:**	**Grade:**
_____	_____	_____	_____
_____	_____	_____	_____

If parents cannot be reached in case of illness or accident call: (PLEASE PRINT CLEARLY)

Name:_____ **Phone No:**_____

Relationship to you:_____

Name:_____ **Phone No:**_____

Relationship to you:_____

Father's place of employment:_____**Work No.**_____

Mother's place of employment:_____**Work No.**_____

Preferred Doctor:_____**Phone No.**_____

Preferred Dentist:_____**Phone No.**_____

Preferred Hospital:_____**Phone No.**_____

Pertinent facts concerning your child's medical history to which the school or a doctor should be alerted:

Allergies? (If none, state No)_____**Diabetic?** Yes _____No

Other:_____

Medication(s) (name and dosage):_____

_____

_____

Diagnoses:_____

_____

Emergency Medical Authorization

The purpose of the following form is to enable parent/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents and/or guardians cannot be reached **(either Part 1 or Part II must be completed)**

PART I

I hereby give my consent, in the event of reasonable attempts to contact either parent or guardian have been unsuccessful, for (1) the administration of any treatment deemed necessary by my preferred doctor or dentist, or in the event the designated preferred doctor or dentist is not available, by another licensed doctor or dentist, and 92) the transfer of the child to my preferred hospital or any hospital reasonably accessible.

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

Date:_____ **Parent/Guardian(s) Signature:**_____

PART II

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:

_____

_____

Date:_____ **Parent/Guardian(s) Signature:**_____