EMERGENCY MEDICAL FORM 2023-2024

Student Name:_______________________________ **Home No.**___________________________ **Cell No.**______________________
Address:____________________________________ **City:**_________________ **State:**__________ **Zip:**__________________
Date of Birth:__________________________ **Sex:**___________

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:

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Date:__________________________ **Parent/Guardian(s) Signature:**____