PUPIL RELEASE - EMERGENCY PROCEDURE - MEDICAL AUTHORIZATION

Student Name:____________________________________Grade:________Date of Birth:_________________

Please check one: bus rider_______________ (bus #)________ pick – up_________________ walker__________________

Custodial Parent/Guardian Names:______________________________________ Parents' E-mail:_________________________

Address:____ Home Phone:______________________________________

____ Cell Phone(s):___________________________________

Child Lives with:____(Relationship)_____________________________

Parents are: _____Married _____ Divorced _____Separated _____Mother Deceased _____Father Deceased

Father's Name:______________________________________

Address:____

____

Father's DAYTIME Phone(s):__________________________

Occupation/Employer:____________________________________

____

Mother's Name:____________________________________

Address:____

____

Mother's DAYTIME Phone(s):_______________________

Occupation/Employer:______________________________

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In case of emergency, illness or accident to the child named above, the school is authorized to proceed as indicated below. (Please number each item 1, 2, 3, etc., in order of desired action):

#___Contact father at phone listed above or ________________ # ___Take child to ____________________________ Hospital

#___Contact mother at phone listed above or_______________ #___Take child to any licensed physician

#___Contact family physician _____________________Phone___________ or dentist__________________Phone:___________

#___Other____

If parent or guardian is unavailable, please designate below those individuals to whom your child may be released. These individuals may be contacted for child illness, early dismissal, or emergency:

Name	Relationship	Daytime Phone

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

(Either Part I [To Grant Consent] or Part II [Refusal to Consent) MUST be "X'd" and completed)

_____***PART I*-Grant Consent:** In the event reasonable attempts to contact me at (phone) ______________________ or to contact _______________________ at (phone)_____________________ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the doctor or dentist listed above or, in the event the designated preferred practitioner is not available, by another licensed practitioner; and (2) the transfer of the child to _________________________________ Hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies (i.e. bee stings, medications, etc.), medications currently being taken, food supplements, modified diets, fluoride supplements and any physical impairments to which a physician should be alerted:

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Signature of Parent:____ Date:___________________________

****Do Not Complete Part II if you completed Part I****

_____***PART II*-Refusal to Grant Consent**: I DO NOT give 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:

Signature of Parent:____ Date:___________________________