PUPIL RELEASE - EMERGENCY PROCEDURE - MEDICAL AUTHORIZATION

Student Information for CMS School Year: _____ **Bus #** _____ **Grade/Homeroom #** _____

Student's Last Name _____ **First Name** _____ **Date of Birth** _____

Custodial Parent/Guardian Name(s) _____

Address _____ **Parent's E-mail** _____

_____ **Home/Cell Phone** _____

Child Lives with _____ **Relationship** _____

Parent are: _____ **Married** _____ **Divorced** _____ **Separated** _____ **Mother Deceased** _____ **Father Deceased**

Father's Name _____ **Mother's Name** _____

Address _____ **Address** _____

_____ _____

Father's DAYTIME Phone # _____ **Mother's DAYTIME Phone #** _____

Employer _____ **Employer** _____

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 Mother at phone listed above or** _____ **#** ____ **Take child to** _____ **Hospital**

____ **Contact Father at phone listed above or** _____ **#** ____ **Take child to any licensed physician**

____ **Contact Family Doctor** _____ **Phone** _____

____ **Contact 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

** Complete and "x" EITHER Part I - To Grant Consent OR Part II - Refusal to Consent **

_____ **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 the following 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 surgery is performed.**

Please list facts concerning the child's medical history including allergies (i.e. bee stings, medications, etc.), medications currently being taken, and any physical impairments to which a physician should be alerted:

_____

Signature of Parent/Guardian _____ **Date** _____

****Do Not Complete the following Part II if you completed Part I above****

_____ **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 either take no action or to** _____

Signature of Parent/Guardian _____ **Date** _____