PRINT RESET

EMERGENCY MEDICAL INFORMATION/AUTHORIZATION FORM

5341 F1
6/07

EMERGENCY MEDICAL INFORMATION

Student's Name _____ M/F _____ Grade or HR _____
(*last*) (*first*) (*m.i.*)

Street Address _____ School _____

City _____ Zip Code _____ Home Phone _____

Birth Date _____

Name of Legal Guardian _____ Teacher/Team _____

With whom does the child reside? _____ Bus _____

Non-custodial parent may be contacted in the event I cannot be reached: ( ) Yes ( ) No

Name of non-custodial parent/guardian _____ Phone No. _____

Mother's Name _____ Home# _____ Work# _____

Place of Employment _____ Cellular# _____ Pager# _____

Mother's Primary Email _____ Mother's Secondary Email _____

Father's Name _____ Home# _____ Work# _____

Place of Employment _____ Cell# _____ Pager# _____

Father's Primary Email _____ Father's Secondary Email _____

** List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:*

Name _____ Name _____

Address _____ Address _____

Telephone _____ Telephone _____
(home) (work) (home) (work)

Known Allergies: _____

Current Medications: _____

Health Concerns (e.g.: diabetes, asthma): _____

Physical Impairments: _____

Name(s) of Immunization(s) given within last year; please include date(s): _____

_____

EMERGENCY MEDICAL AUTHORIZATION — PART 1 *OR* PART 2 MUST BE COMPLETED:

Part 1 (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____(*phone*) or _____ (*phone*) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____at_____ (*phone*) or Dr. _____ at _____ (*phone*), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to_____(*hospital name*) 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 necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Legal Guardian_____ Date _____

complete by hand

Part 2 (REFUSE TO GRANT CONSENT) (Do not complete Part 2 if you completed Part 1)

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 the following action: _____

_____

Signature of Legal Guardian _____ Date _____

complete by hand

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