2019-2020 Authorization for Emergency Response

Student Name: _____ Home#: _____

DOB_____ M/F_____ Upcoming Grade _____

Guardian/Mother_____ cell#_____Employer/#_____

Guardian/Father_____cell#_____Employer/#_____

Student lives at residence (please check one): _____Mom/Dad together _____Mother _____Father _____Grandparent(s)
_____Guardian(s) _____Student alternates between living at mother's and father's residence throughout school year

Medical Information:

Allergies (describe the type of reaction, frequency and severity-give details if emergency treatment may be required or if an MD should be alerted)

Food Allergies:_____Drug Allergies:_____

Environmental/Other Allergies:_____

Daily medications:_____ Emergency Medications (i.e. Epi-pen/Inhaler)_____

Student's current medical, emotional, or surgical conditions: (i.e. Diabetes, Asthma, frequent upper respiratory infections, Seizures, Scoliosis, Anemia, Arthritis, Cystic Fibrosis, Eczema or other skin conditions, Behavior problems, Depression, Cardiac Surgery or any other): Please comment as you feel necessary on any of these:_____

_____

_____

Contact and Release Information (please note this list is exclusively for Emergency Response)
If a parent cannot be reached, these people should be contacted, and my child has permission to be released to:

Name	Relationship	Phone

Never release my child to:_____(a photo and explanation of situation must be included. Custody papers must be on file if you are divorced)

Preferred Physician
Dr._____
Phone: _____

Preferred Dentist
Dr._____
Phone: _____
Does your student wear glasses? (Y/N)

Does your student wear contacts? (Y/N)

Medical Consent

PART I: To Grant Consent

In the event that I cannot be contacted, I hereby give consent for the administration of any treatment deemed necessary by my preferred physician, dentist, or by another licensed physician, time permitting (*This authorization covers major surgery only when the medical opinions of two other licensed physicians or dentists concur on the necessity of such surgery before it is performed)*. If emergency transportation is needed, our child may be transported in a privately-owned car or commercial vehicle at the family's expense.

_____

PARENT SIGNATURE & DATE

PART II: To Refuse Consent

I do not give my consent for emergency medical treatment of my child. I wish the school to take no action or to take the following action:

_____

PARENT SIGNATURE & DATE