EMERGENCY MEDICAL FORM

GRADE / HOMEROOM TEACHER _____ .

Student's Name _____ Date of Birth _____

Address _____
Street City Zip

Please choose ONE and only ONE option below for automated phone calls. This is the number that the district will use to notify you of snow days, emergencies, attendance, and general messages from the schools.

☐ **Home#:** (___) _____ ☐ **Cell #** (___) _____ ☐ **Other #** _____

WHO HAS LEGAL CUSTODY OF THE ABOVE CHILD? _____

Please circle all of the following that apply to the above child:

Child lives with:

Parents Mother Father Guardian Foster Parents Grandparents Other _____

Parental Marital Status:

Father Deceased Mother Deceased Parents Separated Married Never Married Divorced

Father/Stepfather's Name _____ Home Phone _____

Mailing Address _____ City/Zip Code _____

Father Employed by _____ City _____

Occupation _____ Business Phone (___) _____ Cell Phone (___) _____

Personal E-Mail Address _____

Mother/Stepmother's Name _____ Home Phone (___) _____

Mailing Address _____ City/Zip Code _____

Mother Employed by _____ City _____

Occupation _____ Business Phone (___) _____ Cell Phone (___) _____

Personal E-Mail Address _____

Guardian Name _____ Home Phone (___) _____

Mailing Address _____ City/Zip Code _____

CONTINUE ON BACK.....

STUDENT UPDATE

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT – I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Local Hospital: _____ Phone: _____

Medical Facts – Please list all facts concerning the child's medical history including allergies, medications taken, and any physical impairments to which a physician should be alerted -

_____

_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available by another licensed physician or dentist; and (2) the transfer of the child to 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 prior to the performance of such surgery.

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

PART II – REFUSAL TO CONSENT (Do not complete this portion if PART I was completed)
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 actions:

_____
_____
_____

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

_____

☐ **I DO NOT AUTHORIZE** the release of photographs , video, or the cable broadcast of my child to school publications, school web sites and local newspapers covering student activities, sporting events, and other articles.

AUTHORIZED EMERGENCY PICK-UP WHEN ILL OR INJURED AT SCHOOL

PURPOSE: To authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **THIS IS NOT FOR PICK-UP AT THE END OF THE DAY:**

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

If any of these people cannot be reached, the student will stay in school and return to class.
If any information (phone numbers, addresses, custody, etc.) change, please promptly notify the school.