

EMERGENCY MEDICAL FORM

Student/Parent Name (please circle): _____ Home Ph. No. _____

Address: _____ City: _____ State _____

Zip Code: _____ Birth date of Student _____ Cell Ph. No. w/area code _____

PURPOSE: To enable parents/guardians/medical personnel to authorize the provisions of emergency treatment for children/staff/chaperones who become ill or injured while under school authority when parents/guardians/spouses/relatives cannot be reached.

Residential Parent/Guardian of Student

Mother's Name: _____ Daytime Ph. No. _____

Father's Name: _____ Daytime Ph. No. _____

Parent's e-mail address: _____

Where can parent(s) be reached while student is at _____? _____ Cell Ph. No. _____

Other's Name for student in case above cannot be reached: _____

Relationship: _____ Phone No. _____

Address: _____ City: _____ State _____

Other's Name for Staff/Chaperones: _____

Relationship: _____ Phone No. _____

Address: _____ City: _____ State _____

PART I OR PART II MUST BE COMPLETED for Student/Staff/ Chaperones

PART I – To Grant Consent – I hereby give consent to the following medical care providers and local hospitals to be called:

Doctor: _____ Ph. No: _____

Dentist: _____ Ph. No: _____

Medical Specialist: _____ Ph. No: _____

Local Hospital: _____ Emergency Ph. No: _____

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 another licensed physician or dentist; and, (2) the transfer of the student/staff/chaperone to any hospital reasonably accessible. This authorization does NOT cover major surgery unless the medical opinions of two other licensed physicians or dentist concurring in the necessity for such surgery are obtained to the performance of surgery.

Facts concerning the students/staff/chaperones medical history including allergies, medications being taken and physical impairments in which a physician should be alerted to: _____

Signature of Parent for Student: _____ Date: _____

Signature of Staff Member/Chaperone (please circle): _____ Date: _____

PART II - Refusal to Consent (Do not complete this portion if Part I was completed)

I do **NOT** give my consent for emergency treatment of my child/myself (staff/chaperone) in the event of illness or injury requiring emergency treatment. I wish for the school authorities to take the following actions: _____