

MIDDLETOWN CITY SCHOOL DISTRICT EMERGENCY MEDICAL AUTHORIZATION 6-A

Student Name _____ DOB: ____/____/____ Phone _____

Address _____

School _____ Grade _____ Homeroom _____

The purpose of this form is to enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached, and to authorize the release of medical information to school officials/employees who have responsibility for the student while the student is at school or school events and/or is being transported by the schools.

.....**PART 1 OR 2 MUST BE COMPLETED**.....

PART 1 – TO GRANT CONSENT: (Identify if applicable)

Mother’s Name: _____ Daytime Phone: _____ Cell _____

Email: _____

Father’s Name: _____ Daytime Phone: _____ Cell _____

Email: _____

Guardian: _____ Daytime Phone: _____ Cell _____

Emergency Contacts (will be called in the order given if parent/guardian CANNOT be reached)

- 1. Name: _____ Relationship: _____ Phone: _____ Cell: _____
- 2. Name: _____ Relationship: _____ Phone: _____ Cell: _____
- 3. Name: _____ Relationship: _____ Phone: _____ Cell: _____
- 4. Name: _____ Relationship: _____ Phone: _____ Cell: _____

Emergency Care Information

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred local Hospital: _____ Phone: _____ Fax: _____

Allergies and/or Specific Health Considerations: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for administration of any treat deemed necessary by the mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 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 performance of such surgery. In addition, I give my permission for any and all medical information be to shared with all school personnel that interact with my child.

Parent/Guardian Signature: _____ Date: _____

.....
PART 2 – TO REFUSE CONSENT:

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 no actions or to: (please explain) _____

Parent/Guardian Signature: _____ Date: _____