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.

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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:____
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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:__________________________

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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)____
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Parent/Guardian Signature:____ Date:______________________________