



Demographic information on this form has been updated for 2010–2011: No  Yes

5341 F1  
Jun 10

# Emergency Medical Information/Authorization Form

*This form requires legal guardian's signature.*

## Emergency Medical Information

Student's Name \_\_\_\_\_ M/F \_\_\_\_\_ Home Phone \_\_\_\_\_  
*last first mi*

Street Address, City, Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Student Cell Phone \_\_\_\_\_ Student Email \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher/Team \_\_\_\_\_ Bus \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

This child resides with... \_\_\_\_\_ Second/Shared Parent \_\_\_\_\_

Second/Shared parent information \_\_\_\_\_  
*street address city state zip home phone cell phone*

Non-custodial parent may be contacted in the event you or shared parent cannot be reached: Yes [ ] No [ ] \_\_\_\_\_  
*Name of non-custodial parent*

Non-custodial parent information \_\_\_\_\_  
*street address city state zip home phone cell phone*

**• Please list two neighbors or nearby relatives who will assume temporary care of your child if you or the shared or non-custodial parent cannot be contacted:**

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_  
*home cell home cell*

Known Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Health Concerns (e.g.: diabetes, asthma): \_\_\_\_\_

Physical Impairments: \_\_\_\_\_

Name(s) of Immunization(s) Given within Last Year; Please Include Dates: \_\_\_\_\_

## Emergency Medical Authorization — Part 1 or Part 2 must be completed:

### Part 1 (TO GRANT CONSENT)

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone) or \_\_\_\_\_ (phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ at \_\_\_\_\_ (phone) or Dr. \_\_\_\_\_ at \_\_\_\_\_ (phone), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to \_\_\_\_\_ (hospital name) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

signature

### Part 2 (TO REFUSE TO GRANT CONSENT) — Do not complete Part 2 if you completed Part 1

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 action: \_\_\_\_\_

Signature of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

signature



# **Corrections only** to Emergency Medical Information on Page 1

Parents: Below, please print **only corrections** to the information on page 1. Thank you!

Student's Name \_\_\_\_\_ M/F \_\_\_\_\_ Home Phone \_\_\_\_\_  
*last first mi*

Street Address, City, Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Student Cell Phone \_\_\_\_\_ Student Email \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher/Team \_\_\_\_\_ Bus \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

This child resides with... \_\_\_\_\_ Second/Shared Parent \_\_\_\_\_

Second/Shared parent information \_\_\_\_\_  
*street address city state zip home phone cell phone*

Non-custodial parent may be contacted in the event you or shared parent cannot be reached: Yes ( ) No ( ) \_\_\_\_\_  
*Name of non-custodial parent*

Non-custodial parent information \_\_\_\_\_  
*street address city state zip home phone cell phone*

• **Please list two neighbors or nearby relatives who will assume temporary care of your child if you or the shared or non-custodial parent cannot be contacted:**

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_  
*home cell home cell*

Known Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Health Concerns (e.g.: diabetes, asthma): \_\_\_\_\_

Physical Impairments: \_\_\_\_\_

Name(s) of Immunization(s) Given within Last Year; Please Include Dates: \_\_\_\_\_

\_\_\_\_\_