

**BELLEFONTAINE CITY SCHOOLS – INTERMEDIATE SCHOOL EMERGENCY MEDICAL AUTHORIZATION**

Student's Name \_\_\_\_\_ Student ID \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_  
Last First Middle Last Initial

Student's Home Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Bus # \_\_\_\_\_  
House Number and Street City Zip

Home Phone \_\_\_\_\_ Has the above address changed from last school year?  yes  no

Purpose – To enable parents & guardians 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.

**The custodial/designated residential parent or legal guardian of this student is** \_\_\_\_\_

With whom does the student reside? \_\_\_\_\_ Phone Number for School Messenger: \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Home Address \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_  
City State Zip

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Home Address \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_  
City State Zip

Relative or Childcare Provider \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ City State Zip

**PART I OR PART II MUST BE COMPLETED**

**Part I: To Grant Consent**

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 the below named physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_ Emergency Room Number \_\_\_\_\_

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 (Mother)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Parent/Guardian (Father)

\_\_\_\_\_  
Date Signed

**Part II: Refusal to 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 the following action:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian (Mother)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Parent/Guardian (Father)

\_\_\_\_\_  
Date Signed

Facts concerning the child's medical history, including allergies, medications being taken and any physical impairments to which a physician should be alerted are:

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**Administration of Tylenol**

I hereby do  /do not  give my permission for 1\_\_\_\_ or 2\_\_\_\_ Tylenol (acetaminophen) tablets to be administered to my child in accordance with the approved procedure.

\_\_\_\_\_  
Signature of Parent/Guardian (Mother)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Parent/Guardian (Father)

\_\_\_\_\_  
Date Signed

**EARLY DISMISSAL/EMERGENCY PICK-UP**

Please list the names and numbers of those we may contact in the event we are unable to reach you. We will ask for identification.

_____ Name	_____ Relationship	_____ Phone
_____ Name	_____ Relationship	_____ Phone
_____ Name	_____ Relationship	_____ Phone
_____ Name	_____ Relationship	_____ Phone

If there is any person who SHOULD NOT BE ALLOWED to pick up your child during school hours, please visit the school office.

\_\_\_\_\_  
Signature of Parent/Guardian (Mother)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Parent/Guardian (Father)

\_\_\_\_\_  
Date Signed