

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 _____
City State Zip Email _____

Father's Name _____ Cell Phone _____

Father's Home Address _____ Work Phone _____
City State Zip Email _____

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:

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