BELLEFONTAINE CITY SCHOOLS – ELEMENTARY 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

~OVER~

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

_____

_____

_____

EARLY DISMISSAL/EMERGENCY PICK-UP

For the protection of your child:

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

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

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Revised 05/2018