EMERGENCY MEDICAL AUTHORIZATION FORM
NORTON CITY SCHOOLS

IMPORTANT: PLEASE PRINT USING BLACK INK (NO GEL PENS PLEASE)!

Student Name _____ BLDG:_____GRADE: ____

Address:_____ Sex: ☐ M ☐ F Birth Date ____/____/____

City/Zip:_____Phone: _____/_____

Parent/Guardian Email Address:_____Student # _____

Parents or Guardians: Authorize emergency treatment by signing ONE of the boxes below.
Part I *or* Part II MUST be completed.
Failure to sign either will give authorization for treatment.

PART I: GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician_____ Phone _____-_____

Dentist _____ Phone _____-_____

Medical Specialist _____ Phone _____-_____

Local Hospital _____

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 above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring the necessity of surgery is obtained prior to the performance of such surgery.

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

1. Medical Condition: _____

_____

2. Allergies _____**EPI-PEN: YES ____ NO_____**

3. Medications: _____

(if medication is required to be administered during school hours, please complete medication forms available on district website.)

4. Bus Driver Medical Information: _____

Signature of Parent/Guardian _____ **Date:** _____

PART II: REFUSE CONSENT

I DO NOT GIVE CONSENT for emergency medical treatment of my child. In the event of illness or injury regarding emergency treatment, I wish the school authorities to take the following action: _____

_____

Signature of Parent/Guardian _____ **Date:** _____

PLEASE LIST ANYONE NOT PERMITTED TO HAVE CONTACT WITH YOUR STUDENT:

(Legal documentation must be provided to be valid.)

Name _____ Relationship to Student: _____

Name _____ Relationship to Student: _____

PLEASE COMPLETE REVERSE SIDE.

EMERGENCY CONTACTS

Please list parent/guardian information followed by relatives or neighbors who you give permission to provide temporary care for your student.

Parent/Guardian:

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

Parent/Guardian:

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

Additional Contact:

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

Additional Contact:

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

Additional Contact:

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

FOR PRESCHOOL, ELEMENTARY AND MIDDLE SCHOOL USE ONLY: CHILD CARE PROVIDER

Name _____ Relationship to Student _____

Address _____

Daytime Phone_____-_____Cell Phone _____-_____

MILITARY FAMILY INFORMATION

Is student a dependent of a member of the military forces? □ YES □ NO

If yes, who? □ Mother □ Father □ _____

□ National Guard □ Reserves □ Active Duty In _____ branch.