

# EMERGENCY MEDICAL AUTHORIZATION



For the School Year of September \_\_\_\_\_ through August \_\_\_\_\_

Minor's Name \_\_\_\_\_ Male Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_ School District \_\_\_\_\_

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

Name of Legal Guardian: \_\_\_\_\_

Name(s) of person with whom the student resides: \_\_\_\_\_

Permission to contact non-custodial parent? Yes No NA

If yes, name and phone of that parent \_\_\_\_\_ Phone \_\_\_\_\_

Known allergies: \_\_\_\_\_ Health Concerns (asthma, diabetes, etc.) \_\_\_\_\_

Any known food allergies: \_\_\_\_\_ Current medications: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

An authorization of the provision of emergency treatment for students who become ill or injured while involved in a Grace Church function. PLEASE LIST ONLY THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOLVING THIS STUDENT. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e. 1<sup>st</sup>, 2<sup>nd</sup>).

# \_\_\_\_\_ Mother (Name) \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Employment \_\_\_\_\_ Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

# \_\_\_\_\_ Father (Name) \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Employment \_\_\_\_\_ Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

# \_\_\_\_\_ Other (Name) \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

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

## ***PART 1 OR PART 2 MUST BE COMPLETED***

### **PART 1**

I hereby consent for the following medical care providers to be called:

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

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

### **PART 2**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury

I wish Grace Church at Willow Valley to take the following action: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_