Date:_____

_____Grade

_____

Teacher

Clinton-Massie Local School District

Emergency Medical Authorization and Student Information

Please Print Clearly

Student's Name_____ Date of Birth_____

Address_____ Social Security #_____

P.O. Box_____ _____Male _____Female

City/State/Zip_____ County_____

Home Telephone # _____ Lives with _____

Mother _____ Cell #_____ Work #_____

Father _____ Cell #_____ Work #_____

Legal Guardian(s) _____ Cell #_____ Work #_____

Parent/Guardian E-mail address_____

In case of EMERGENCY/ILLNESS contact please list additional contacts in case a parent/guardian cannot be reached**:**

Name	Relationship	Cell Phone	Home Phone
1.			
2.			
3.			

- To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached, **PART I or PART II MUST BE COMPLETED.**

PART I- TO GRANT CONSENT:

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

Doctor: _____ Phone#_____

Dentist: _____ Phone#_____

Medical Specialist:_____ Phone#_____

Local Hospital: _____

In the event that 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 doctor or dentist. In the event the designated preferred practitioner is not available, by another licensed physician or dentist.
(2) The transfer of the child to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of the two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Medical conditions or special needs: ___Diabetes ___Asthma ___Seizures ___Physical limitations
___Emotional Needs ___Allergies: Medication/Food/Bee-sting/Other ___Severe Allergic Reaction ___Other Conditions
Describe any conditions marked above: _____
Current Medication(s): _____ **N**eeded at school? __**Yes** __**No**
Permission granted for school health screenings such as scoliosis, dental, or blood pressure? __**Yes** __**No**
(Exemptions from mandatory hearing and vision screenings require a note from your doctor or optometrist.)

Signature of Parent/Guardian *Printed Name* *Date*

PART II-REFUSAL TO CONSENT:

I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take no action or the following action: _____

Signature of Parent/Guardian *Printed Name* *Date*