URBANA CITY SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents/guardian to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardian cannot be reached. **Parent or guardian will always be notified as soon as possible.**

Student Name: ___________________________________ School: ________________ Teacher/Grade:_____________

Address: ____ Home Phone: _______________

Additional Contact Information for those **who have authority** to make decisions in an emergency situation involving this student. Please provide information for those individuals that have this authority **ONLY**.

Mother __________________________ Home #: __________________ Work #: ___________________ Mobile #: __________________

Father: __________________________ Home #: __________________ Work #: ___________________ Mobile #: __________________

Step Parent __________________________ Home #: __________________ Work #: ___________________ Mobile #: __________________

Guardian: __________________________ Home #: __________________ Work #: ___________________ Mobile #: __________________

Alternate: __________________________ Home #: __________________ Work #: ___________________ Mobile #: __________________
(Relative or child care provider)

The persons listed below are permitted to sign out your child from school. If a person is not listed, they will not be permitted to sign your child out without further consent from you.

Name: ____ Relationship- __________________ Phone #: ______________________________

Name: ____ Relationship- __________________ Phone #: ______________________________

Name: ____ Relationship- __________________ Phone #: ______________________________

Date: __________________ **Signature of Parent / Guardian**: ____

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY, INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:

____

____

CHECK ALL THAT APPLY: CONTACTS ____ GLASSES____ BRACES: ____ HEARING AIDS:_____ASTHMA:____ DIABETES _____ SEIZURES ____

COMPLETE PART 1 TO GRANT CONSENT FOR MEDICAL TREATMENT

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: ____ Phone: ________________________________

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 reasonably accessible.
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 each surgery.

____ ____

Parent/Guardian Signature Date

COMPLETE PART II TO REFUSE CONSENT FOR MEDICAL TREATMENT

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 school authorities to take the following action:

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Parent/Guardian Signature: ____ Date: _________________________