2011-2012

CAMPBELL CITY SCHOOLS

Emergency Medical Authorization

Student Name____ _______________
(First) (Middle Initial) (Last) Date of Birth

Student Address ____ **Grade** _______

Purpose—To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents and guardians cannot be reached. Those individuals listed below have my permission to pick up my child.

****PART 1: TO GRANT REQUEST (Please Print) MUST BE COMPLETELY FILLED OUT!**

Mother's Name or Legal Guardian	Home Phone	Work Phone	Cell Phone
Father's Name or Legal Guardian	Home Phone	Work Phone	Cell Phone
Emergency Contact #1	Home Phone	Work Phone	Cell Phone
Emergency Contact #2	Home Phone	Work Phone	Cell Phone

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

Physician ______________________________ **Phone** ______________

Dentist ______________________________ **Phone** ______________

Medical Specialist ______________________________ **Phone** ______________

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

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____

I authorize administration of **Tylenol** (acetaminophen) ____ **(yes)** ____ **(no) (check one)**, and or **Benadryl** (diphenhydramine HCL) ____ **(yes)** ____ **(no) (check one)** to be given by a qualified personnel, if deemed necessary according to School Board Policy. I release and agree not to hold the Board of Education, its officials, and its employees responsible for any and all liability for damages or injury resulting directly or indirectly from this authorization.

I HEREBY GIVE MY CONSENT in the event reasonable attempts to contact me have been unsuccessful for (1) the administration of any treatment deemed necessary by above named doctors during the school year, 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 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—(Part 1)** **Date**

****PART 2: REFUSAL TO CONSENT (Please sign below if you refuse 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:

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______________________________________ _______________
****Signature of Parent/Guardian--(Part 2)** **Date**

***Please turn over**

Name and grade of siblings attending Campbell Schools:

Name: ______________________________ **Grade**: __________

Name: ______________________________ **Grade**: __________

Name: ______________________________ **Grade**: __________

Name: ______________________________ **Grade**: __________

Email Address: ____

*(Revised-January 2010)