WICKLIFFE CITY SCHOOLS
Emergency Medical Authorization Form

Student Name: ______________________________ Homeroom Teacher: ____________________ Grade: ______
Last First

Home Address: ______________________________ Date of Birth: ______________ Student ID # ____________

Home Phone: ____________________ Unlisted: Y or N

☐ **RESIDENTIAL PARENT/GUARDIAN:**

Name/Relationship: ______________________________

Home Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Email Address:* ______________________________

Employer: ______________________________

Work Phone: ______________________________

☐ **RESIDENTIAL PARENT/GUARDIAN:**

Name/Relationship: ______________________________

Home Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Email Address* ______________________________

Employer: ______________________________

Work Phone: ______________________________

*The district cannot assume responsibility for the confidentiality of educational information disclosed through electronic correspondence.

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STUDENT MEDICAL AUTHORIZATION

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 or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at ______________ (phone number) or ____________________ (other parent or guardian) at ______________ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ______________ (phone) ____________ (address) ______________________________ (preferred physician), or Dr. ______________ (phone) ____________ (address) ______________________________ (preferred dentist), or, in the event the designated practitioner is not available, by another licensed physician or any hospital reasonably accessible.

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

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

____

____

Date ____________________ ______________________________
Signature of Parent or Guardian

PART II REFUSAL TO CONSENT

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

____

____

Date ____________________ ______________________________
Signature of Parent or Guardian **(DO NOT SIGN IF YOU SIGNED PART 1)**

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ADDITIONAL EMERGENCY CONTACTS THE STUDENT MAY BE RELEASED TO:

Name: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Work Phone: ______________________________

Name: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Work Phone: ______________________________