WICKLIFFE CITY SCHOOLS
Emergency Medication 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:**		☐ **RESIDENTIAL PARENT/GUARDIAN:**	
Name/Relationship:	____	Name/Relationship:	____
Home Address:	____	Home Address:	____
Home Phone:	____	Home Phone:	____
Cell Phone:	____	Cell Phone:	____
Email Address:*	____	Email Address*	____
Employer:	____	Employer:	____
Work Phone:	____	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:	______________________________________	Name:	_______________________________________
Home Phone:	______________________________________	Home Phone:	_______________________________________
Cell Phone:	______________________________________	Cell Phone:	_______________________________________
Work Phone:	______________________________________	Work Phone:	_______________________________________