SOUTH RANGE LOCAL SCHOOLS

2017-2018

Student Information / Emergency Medical Authorization Form

****This form is to be completed by parent/guardian ONLY.**

Student Information

Student Name _____ Grade _____

Student Address _____
Street / P.O. Box or Apt. # **City** **State** **Zip**

Birth Date _____ Bus Number _____ Student's Cell Phone Number _____

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never married

Student lives with: ☐ Both Mother & Father ☐ Mother ☐ Father ☐ Step-parent ☐ Guardian

Legal Custody: ☐ Both Mother & Father ☐ Mother ☐ Father ☐ Step-parent ☐ Guardian

Mother/Guardian First & Last Name: _____

Address (if different from student): _____
Street City State Zip

Place of Employment: _____

Father/Guardian First & Last Name: _____

Address (if different from student): _____
Street City State Zip

Place of Employment: _____

Name of Sibling(s) Attending South Range Schools	Grade
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***Please fill out emergency medical information on reverse side.**

Emergency 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 and/or guardians cannot be reached.)

ORDER TO BE CALLED

____	Mother/Guardian	Home Phone	Cell Phone	Work Phone
____	Father/Guardian	Home Phone	Cell Phone	Work Phone
____	Step-Mother	Home Phone	Cell Phone	Work Phone
____	Step-Father	Home Phone	Cell Phone	Work Phone
____	Emergency Contact / Relationship	Home Phone	Cell Phone	Work Phone
____	Emergency Contact / Relationship	Home Phone	Cell Phone	Work Phone

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

Physician ______________________________ Phone ______________________________

Dentist ______________________________ Phone ______________________________

Medical Specialist ______________________________ Phone ______________________________

Preferred Local Hospital ____

Medicaid: Yes_____ No_____ Insurance: Yes_____ No_____

Medical History

Facts concerning the child's medical history:

Allergies:____

Medications currently being taken:____

Any physical impairment to which a physician or school personnel should be alerted:________________

____

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 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 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 such surgery.

Date ______________________ **Signature of Parent / Guardian** ______________________________________

* *

REFUSAL 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:

____

____

____

Signature of Parent/Guardian ______________________________ Date____________________

Address ____

Street City State Zip