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:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____