

STOW MUNROE FALLS HIGH SCHOOL EMERGENCY MEDICAL FORM

STUDENT NAME _____

HOMEROOM _____

ADDRESS _____

GRADE _____

CITY _____ STATE _____ ZIP _____

BIRTH DATE _____

PLACE OF BIRTH _____

(CITY) _____ (STATE) _____

CELL PHONE _____

MOTHER'S NAME _____

Same address ___ yes ___ no

MOTHER'S PLACE OF EMPLOYMENT _____

EMAIL ADDRESS _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

FATHER'S NAME _____

Same address ___ yes ___ no

FATHER'S PLACE OF EMPLOYMENT _____

EMAIL ADDRESS _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

GUARDIAN (If different than parent) _____

ALTERNATE CONTACT:

NAME _____

RELATIONSHIP _____

PHONE _____

ALTERNATE CONTACT:

NAME _____

RELATIONSHIP _____

PHONE _____

MEDICAL ALERTS: _____

MEDICATIONS: _____

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 or guardians cannot be reached. Part I or Part II must be completed.

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number), or _____ (other parent/guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____, physician/dentist, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. List facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted below.

Signature of Parent/Guardian _____ Date _____

PART II – 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 no action or to

Signature of Parent/Guardian _____ Date _____