SYCAMORE COMMUNITY SCHOOLS
Our students. Our future.

EMERGENCY MEDICAL AUTHORIZATION FORM

The purpose of this form is to enable parents and guardians to authorize emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached. Please be sure to complete each blank.

Student Last Name_____ Student First Name_____ Sex: M F

Date of Birth_____ Student ID# _____ Grade _____

Student Home Address _____ Zip Code_____ Home Ph. #_____

Who has legal custody of the student? (name and relationship)_____

Mother's Name _____ Mother's Email _____

Mother's Address (if different from student)_____

Mother's Home #_____ Mother's Work #_____ Mother's Cell #_____

Which of the above numbers is the best way to contact the mother? ❑ Home # ❑ Work # ❑ Cell #

Father's Name _____ Father's Email _____

Father's Address (if different from student) _____

Father's Home #_____ Father's Work #_____ Father's Cell #_____

Which of the above numbers is the best way to contact the father? ❑ Home # ❑ Work # ❑ Cell #

Step Parent's Name _____ Step Parent's Address (if different from student)_____

Step Parent's Home #_____ Step Parent's Work #_____ Step Parent's Cell #_____

LOCAL ALTERNATE CONTACT NAMES (CONTACTS IN A MEDICAL EMERGENCY IN THE ABSENCE OF PARENT/GUARDIAN)

Name 1_____ Home # _____ Cell # _____

Relationship to student _____

Name 2_____ Home # _____ Cell # _____

Relationship to student _____

******* PART I OR PART II BELOW MUST BE COMPLETED AND SIGNED *******

PART I - TO GRANT CONSENT. I hereby give consent for the following medical care providers/local hospital to be called:

Doctor's Name	Phone #	Address
Dentist's Name	Phone #	Address
Medical Specialist (optional)	Phone #	Address
Local Hospital	ER Phone #	Address

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 doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of my child to preferred hospital or 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. **I have listed below facts concerning my child's medical history including medical conditions (Diabetes, asthma, allergies, ADHD, autism, etc.) and medications being taken for physician knowledge:**

_____

Signature of Parent/Guardian _____ Date _____

NOTE: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.

******* DO NOT COMPLETE PART II IF YOU COMPLETED PART I *******

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 school/district authorities to take the following action:

_____

Signature of Parent/Guardian _____ Date _____ (REV. 4-14-14)