



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. This form is also available electronically on the "District Forms" page of the district website, www.sycamoreschools.org, for those who wish to type on the form. However, parents must continue to print out a hard copy of the form, sign it, and return it to the student's school at the beginning of the school year. **Email forms cannot be accepted.***

School Student is Currently Attending _____ A.M. Bus Number _____ P.M. Bus Number _____

Student Last Name _____ Student First Name _____ Sex: M F

Date of Birth _____ Student ID# (if applicable) _____ Grade _____ Homeroom _____

Student Home Address _____ Zip Code _____ Home Ph. # _____

Mother's Employer _____ Father's Employer _____

Mother's Name _____ Mother's Address _____ Mother's Email _____

Mother's Home Ph. # _____ Mother's Wk. Ph.# _____ Mother's Cell Ph/Pager # _____

Father's Name _____ Father's Address _____ Father's Email _____

Father's Home Ph. # _____ Father's Wk. Ph.# _____ Father's Cell Ph/Pager # _____

Step Parent's Name _____ Step Parent's Address _____ Step Parent's Email _____

Step Parent's Home Ph. # _____ Step Parent's Wk. Ph.# _____ Step Parent's Cell Ph/Pager # _____

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

Please list the child care provider, if applicable _____ Child Care Provide Phone # _____

NAMES OF RELATIVE/CARE PROVIDER/ALTERNATE CONTACT (WHO TO CONTACT IN THE ABSENCE OF PARENT/GUARDIAN)

Name _____ Address _____ Daytime Phone # _____ Relationship _____

Name _____ Address _____ Daytime Phone # _____ Relationship _____

******* 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
<p>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 the 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.</p> <p>Facts concerning the child's medical history including medical conditions (ex. Diabetes, asthma, significant allergies, ADHD, autism, Down Syndrome, hearing/vision impairments, etc.) and medications being taken to which a physician should be alerted:</p>		
<p>Signature of Parent/Guardian _____ Date _____</p> <p><i>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.</i></p>		

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

PART II - REFUSAL TO CONSENT <u>I DO NOT</u> 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. 7-13)		