GRADE_____ **SCHOOL**_____

D.O.B._____

AURORA SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION

Student Name_____**Address**_____

Home Phone_____**Custodial Parent(s) [ ] Mother [ ] Father [ ] Both**

Name_____**[ ] Mother [ ] Step Mother [ ] Other**_____

Place of Employment_____**Work Phone**_____**Cell Phone**_____

Name_____**[ ] Father [ ] Stepfather [ ] Other**_____

Place of Employment_____**Work Phone**_____**Cell Phone**_____

Other relative or neighbor to be called and student released to if the above person cannot be contacted:

Name_____**Phone**_____**Relationship**_____**or**
Name_____**Phone**_____**Relationship**_____ **If applicable, restrictions regarding students release during the day** _____ **Is there a court order which limits/prohibits non custodial parent contact? YES NO If yes is circled, parent must contact the office, and provide legal documentation.**

PART I – TO GRANT CONSENT

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist_____ Phone _____

I hereby authorize Aurora City Schools personnel to administer basic first aid to my child in the event of minor injury on the bus or during school sponsored activities or field trips. Parents will be contacted if more extensive treatment is required.

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 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date_____ **Signature of Parent or Guardian** _____

PART II- REFUSAL TO CONSENT

I DO NOT GIVE CONSENT FOR EMERGENCY MEDICAL TREATMENT

Date_____ **Signature of Parent or Guardian** _____