



# EMERGENCY MEDICAL AUTHORIZATION FORM

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**Student's Last Name      Student's First Name      Student's Middle Name      Birthdate      Grade**

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**Student's Home Address      City, State, Zip      Parent's Email**

**PURPOSE** - To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians cannot be reached.

**Circle One:**      Both Parents | Mother Only | Father Only | Guardian/Foster/Host | Grandparent | Mother-Stepfather | Father-Stepmother | Self  
**Student Lives With:**

**Parent/Guardian gives KCCC permission to contact the following:**

RELATIONSHIP	NAME	HOME PHONE	PERMISSIONS
Mother/Guardian		Home #: ( ) _____ - _____ Cell #: ( ) _____ - _____ Work #: ( ) _____ - _____ Employer: _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b> Has Legal Custody: <b>Yes</b> <b>No</b> <i>If Yes, must provide documents</i>

**Mother/Guardian Address (if different from student):**

Father/Guardian		Home #: ( ) _____ - _____ Cell #: ( ) _____ - _____ Work #: ( ) _____ - _____ Employer: _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b> Has Legal Custody: <b>Yes</b> <b>No</b> <i>If Yes, must provide documents</i>
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**Father/Guardian Address (if different from student):**

Step Mother		Phone #: ( ) _____ - _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b>
Step Father		Phone #: ( ) _____ - _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b>
Other:		Phone #: ( ) _____ - _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b>
Other:		Phone #: ( ) _____ - _____	Emergency Contact: <b>Yes</b> <b>No</b> Can Pick-Up Student: <b>Yes</b> <b>No</b>

**EMERGENCY MEDICAL AUTHORIZATION - Part 1 OR Part II below must be completed.**

<b>CONSENT FOR TREATMENT</b>	<b>REFUSAL TO CONSENT</b>
<p>I hereby give consent for the medical care providers and local hospital to be called. In the event reasonable attempts to contact me or the other parent have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the 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.</p> <p><b>Preferred Physician:</b> _____ Phone #: _____</p> <p><b>Preferred Dentist:</b> _____ Phone #: _____</p> <p><b>Medical Specialist:</b> _____ Phone #: _____</p> <p><b>Preferred Hospital:</b> _____ ER Number: _____</p> <p><b>Parent/Guardian Signature:</b> _____ <b>Date:</b> _____</p>	<p>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 the following action:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Parent/Guardian Signature: _____</p> <p>Address: _____</p> <p>Date: _____</p>

**MEDICAL HISTORY:** Facts concerning the child's medical history including allergies, medications being taken, date of last tetanus shot, and any physical impairment of which a physician and/or school personnel should be alerted.