Grade _____ **Northmor Local Schools** **Bus _____**

Date _____ **Emergency Medical Authorization**

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 or guardians cannot be reached.

Pupil Name_____

Home Address_____City_____Zip_____

Home Phone (_____)- _____- _____ Soc. Sec. No. _____-_____-_____

Date of Birth_____/_____/_____ Sibling. _____Age____ Sibling _____ Age ____

Sibling _____Age ____ Sibling _____Age ____ Sibling _____ Age ____

Name/Names of responsible adult/adults student is living with: _____

Phone # you wish to be reached at if your student is absent from school: _____ - _____ - _____

Mothers Name_____ Place of Employment_____

Cell Phone _____ Work Phone _____

Fathers Name _____ Place of Employment_____

Cell Phone _____ Work Phone_____

Parent has Active Duty status: Army____ Navy ____ Air Force ____ Marine Corps ____ Coast Guard ____ National Guard ____

Other Contacts-List by Priority:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Medication Taken Regularly_____

Allergies: _____Medication_____ Food_____

Health Concerns_____

Special Instuctions_____

Medical Doctor_____ Phone_____

Dentist _____ Phone_____

Eye Doctor_____ Phone_____

Preferred Hospital_____

Please contact the school if there is medical information that you wish not to be shared.

Parent Signature_____

Part I or Part II Must Be Completed

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, 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 opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent Signature_____ 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 that school authorities take the following action. _____

Parent Signature_____ Date_____

Permanent Field Trip Permission

_____ has my permission to attend all school sponsored field trips during current year.

(Students Name)

Written notice of each trip will be sent home prior to trip **Parent Signature**_____