2017 - 2018
EMERGENCY MEDICAL AUTHORIZATION
WINTON WOODS CITY SCHOOLS

The purpose of this form is to enable parents and guardians to authorize the provision of 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 print and complete each blank and / or verify the information we have on file regarding your student.

Student ID / Student Name	Date of Birth:	Sex: M_____ F _____
Address:	Home Phone:	Cell Phone:

Medical Information

Please provide facts concerning your child's medical conditions and medications being taken to which a physician should be alerted:

Please check any and all that apply:	**Additional Information:**
_____Asthma: Triggers_____ Inhaler Y / N _____Food Allergies: To What_____Epi Pen Y / N _____Insect Allergies: To What_____Epi Pen Y / N _____Other Allergies: To What_____Epi Pen Y / N _____Diabetes _____Heart Condition _____Seizures _____Vision Problems _____Hearing Problems _____Eating Problems _____ADHD _____Autism _____Other (Explain in Additional Information) **Medications:**	

************YOU MUST SIGN on ONLY ONE of these areas PART I or PART II************

PART I – TO GRANT CONSENT:

I hereby give consent for the following medical care providers / local hospital to be called:

Doctor's Name:	**Phone#**
Dentist's Name:	**Phone#**
Medical Specialist:	**Phone#**
Local Hospital:	**Phone #**

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

Date:_____ Signature of Parent / Guardian: _____

************YOU MUST SIGN on ONLY ONE of these areas PART I or PART II************

PART II – REFUSAL TO CONSENT

I DO NOT give my consent for emergency medical treatment of my child. In the event of the illness or injury requiring emergency treatment, I wish the school / district authorities to take the following action:

Date:_____ Signature of Parent / Guardian _____

PLEASE COMPLETE BOTH SIDES
{TURN PAGE OVER}

Student ID / Student Name

PRIMARY CONTACTS (PARENT / GUARDIAN)

Name	Relationship	Address	Email Address
Home Phone #	Cell Phone #	Work Number#	

Name	Relationship	Address	Email Address
Home Phone #	Cell Phone #	Work Number#	

ADDITIONAL EMERGENCY CONTACTS

Names of Relatives / Care Provider / Alternative Contact (Who to contact in the absence of Parent / Guardian)

First Name	Last Name	Relationship	Cell Phone #	Home Phone #	Work #	Email Address

SIBLINGS IN DISTRICT

First Name	**Last Name**	**School**	**Grade**

Signature:_____ Date: _____

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

Reviewed by School Personnel: _____ (Date)