

EMERGENCY MEDICAL AUTHORIZATION
Berkshire Local School District

Grade _____ Please check box if information has changed

Homeroom Teacher: _____

Student's Name _____
Last First Middle Home Telephone (____) _____

Address _____ PO Box _____ City _____ Zip _____

The legal guardian(s) of this student is/are _____
name and relationship name and relationship

Student's Date of Birth _____

Student living with (check one): Both Parents Joint Custody Mother only Father only Grandparents
 Legal Guardian Foster Family Agency assigned home Other _____

Mother: Daytime Phone (____) _____ Work(____) _____ Cell (____) _____

Father: Daytime Phone (____) _____ Work(____) _____ Cell (____) _____

Non-custodial (or joint custody) parent: Name _____ Address _____

PO Box _____ City _____ Zip _____ Custody Papers? Yes No

List the names, relationship to the student, and phone numbers of those people the school should contact and release the student to in the event of accident or illness. THE LIST SHOULD BE IN THE ORDER OF CALLING PREFERENCE. Please note that every attempt will be made to contact the parent(s) first.

Name	Relationship	Home Phone	Cell Phone/Pager	Work Phone
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

Medical Problems/Allergies/Special Needs:

Diabetes Asthma Seizures Bee/Insect Sting Orthopedic Medication or Food Allergy

Specific Information: _____

Allergic to: _____ Reaction: _____

Current Medication/Treatment: _____

Parent/Guardian Signature is Required on Part I OR Part II

PART I: TO GRANT CONSENT

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

Physician _____ Telephone (____) _____

Dentist _____ Telephone (____) _____

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 doctors, 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 options of (2) other 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 _____

PART II: REFUSAL OF CONSENT

I do **NOT** give my consent to emergency medical treatment of my child. I realize that in a serious emergency school officials will have to call EMS for support. In the event reasonable attempts to contact me have been unsuccessful and my child suffers illness or injury requiring immediate medical care, I wish medical personnel to take the following action:

Date _____ Signature of Parent/Guardian _____