☐ Please check box if contact information has changed. Grade _____

Homeroom Teacher: _____

EMERGENCY MEDICAL AUTHORIZATION

Berkshire Local School District

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

Address _____ PO Box _____ City _____ Zip _____

Student's Date of Birth _____ Student's Nickname: _____ Gender: ☐ Male ☐ Female

Parent Information

Check which applies: ☐ Natural Father ☐ Legally Adoptive Father ☐ Step-Father

Father's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Employer: _____ Business Phone: _____

Cell: _____ Email: _____

Status: (Please check all that apply)

☐ Living with Family ☐ Divorced ☐ Separated ☐ Custodial Parent ☐ Deceased ☐ Custody Papers

Check which applies: ☐ Natural Mother ☐ Legally Adoptive Mother ☐ Step-Mother

Mother's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Employer: _____ Business Phone: _____

Cell: _____ Email: _____

Status: (Please check all that apply)

☐ Living with Family ☐ Divorced ☐ Separated ☐ Custodial Parent ☐ Deceased ☐ Custody Papers

Legal Guardian Information (only complete if above does not apply)

Guardian 1 Name: _____

Guardian 2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Employer: _____ Business Phone: _____

Cell: _____ Email: _____

Status: (Please check all that apply)

☐ Living with Family ☐ Divorced ☐ Separated ☐ Custodial Parent ☐ Deceased

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EMERGENCY MEDICAL AUTHORIZATION – Page 2

Berkshire Local School District

Student's Name _____ Grade _____
Last First Middle

Medical Problems/Allergies/Special Needs:

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

Specific Information: _____

Allergic to: _____ Reaction: _____

Current Medication/Treatment: _____

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.					
3.					
4.					

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 _____

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