

Date: _____

Champion Local School District Emergency Medical Authorization

Bus Number
To _____ From _____

Student: _____
Last First M.I.

Date of Birth: _____

Address: _____
No. Street City

Zip Code: _____

Phone # for attendance/PAM/auto message system: _____

Grade: ____ **Teacher:** _____

This form enables parents and guardians to authorize emergency treatment if their child becomes ill or injured while under school authority. Please complete **Part I to grant consent** or Part II to deny consent. Also, please provide at least three alternate names of persons who are authorized to pick up your child should he/she become ill at school and attempts to reach you are unsuccessful. In case of emergency, please contact the following:

Mother _____	Home _____	Work _____	Cell _____
Father _____	Home _____	Work _____	Cell _____
Guardian(s) _____	Home _____	Work _____	Cell _____

With whom does the child live? Both Parents Mother Father Guardian(s) Shared Parenting

If divorced, does the school have a copy of your most recent custody agreement? Yes No

Address of non-residential parent: _____

If my child becomes ill at school and attempts to contact me have been unsuccessful, I authorize the school to call the following persons who are authorized to pick up my child and will assume emergency responsibility for my child.

Name: _____ **Home Ph.** _____ **Cell Ph.** _____

Relationship to student: _____

Name _____ **Home Ph.** _____ **Cell Ph.** _____

Relationship to student: _____

Name _____ **Home Ph.** _____ **Cell Ph.** _____

Relationship to student: _____

Medical information about my child that authorities need to know (allergies, medications, impairments, etc.):

I give permission to share this information with school personnel for the benefit of my child YES No

Parent Signature _____

I. GRANT CONSENT: In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physicians below, or, if they are not available, by another licensed physician or dentist. I give my consent for my child to be transferred to the hospital below, or to any hospital reasonably accessible. This authorization does not cover major medical surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of each surgery.

Physician _____	Phone _____	Preferred Hospital _____
Dentist _____	Phone _____	
Parent Signature _____		

II. REFUSAL TO GRANT CONSENT: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury that requires emergency treatment, I wish the school authorities to take no action or to:

 Parent/Guardian Signature _____ Date _____

PART ONLY FOR GRADES 5-12 NO Yes, I give permission for my son/daughter to be given Tylenol for simple headaches, uncomplicated menstrual cramps, or orthodontic pain.

Parent/GuardianSignature _____ Date: _____