_____
Date (Office Use)

CHAMPION LOCAL SCHOOL DISTRICT
Emergency Medical Authorization

Bus Number
To____ From ___
CHS: Drives Yes No

Student: _____
Last First M.I.

Date of Birth _____

Address: _____
No. Street City Zip Code

Homeroom Teacher: _____

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

Student Cell Phone: _____

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(Name) _____ Home _____ Work_____ Cell _____
Father (Name) _____ Home _____ Work_____ Cell _____
Guardian(s) _____ Home _____ Work _____ Cell _____

Address of non-residential parent:_____

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

Are Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married
If divorced, does the school have a copy of your most recent custody agreement? ☐ Yes ☐ No

I authorize the school to call the following persons to pick up my child when attempts to contact me are unsuccessful:

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/Guardian 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_____
Dentist_____ Phone_____

Preferred Hospital
_____

Parent/Guardian 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/Guardian Signature_____ Date _____