2019-2020 BTCS EMERGENCY MEDICAL AUTHORIZATION

FAMILY INFORMATION:

Name of Student:		Grade: Weight:
Home Phone:		Birthdate: Age:
Father's Name:	Work Phone:	Other:
Mother's Name:	Work Phone:	Other:
Do you have legal custody and/or guardianship of this child? ❒ Yes ❒ No If you answered no, please list those who do have custody and/or are legal guardians:		
Name:	Address:	Phone:
Name:	Address:	Phone:
Does your custodial parent arrangement affect medical decisions for this child? If so, how?		

MEDICAL INFORMATION:

Specify medical allergies, chronic illnesses, asthmatic conditions, or any other special health conditions of child:	
Family Physician:	Phone:

MEDICATION AUTHORIZATION: (Dosage determined according to age and weight of child)

❒ Yes ❒ No	Children's chewable non-aspirin pain reliever (acetaminophen) (age appropriate dosage)
❒ Yes ❒ No	Pepto-Bismol tablets (age appropriate dosage)
❒ Yes ❒ No	Children's Benedryl (age appropriate dosage)
Do you have any special instructions?	

LOCAL EMERGENCY CONTACTS: (Two adults who will assume responsibility if you cannot be reached)

Name:	Relationship:	Daytime Phone:
Name:	Relationship:	Daytime Phone:

AUTHORIZATION FOR EMERGENCY TREATMENT:

As a parent and/or guardian, I authorize the treatment by a qualified and licensed medical doctor for the above named minor in the event of a medical emergency which, in the opinion of the attending physician is needed to prevent endangerment to the child's life, disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. Necessary first aid may be given at school. This release form is being completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

_____ _____

Signature of Parent or Guardian Date

Name of person filling out form:	Relationship:

February 2019