EMERGENCY MEDICAL AUTHORIZATION FORM

Lancaster City Schools

Has Home/Phone Info changed in the past year? ❑ Yes ❑ No

Please complete in BLUE OR BLACK INK

School ______________________ Student's Name ______________________

Teacher/Grade ______________________ Street ______________________

Date of Birth ______________________ City ______________________ Zip ______________

Home Phone# ______________________ Mother's Cell # ______________________ Father's Cell # ______________________

> **Purpose** -- To enable parents, guardians, alternate persons listed below, to authorize the provision of emergency treatment, including the administration of medication, for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name: ______________________ (First / Last)

Lives with student: ❑ Yes ❑ No

Place of Employment: ______________________

Work Phone (__) ______________________

Ok to contact at work: ❑ Yes ❑ No

Father's Name: ______________________ (First / Last)

Lives with student: ❑ Yes ❑ No

Place of Employment: ______________________

Work Phone (__) ______________________

Ok to contact at work: ❑ Yes ❑ No

Guardian's Name: ______________________ (First / Last)

Lives with student: ❑ Yes ❑ No

Place of Employment: ______________________

Work Phone (__) ______________________

Ok to contact at work: ❑ Yes ❑ No

Alternate Persons to Notify:

Alt # 1 Name: ______________________ Relationship: ______________________

Address: ______________________ Home Phone: (__) ______________________

Cell Phone :(__) ______________________ Work Phone : (__) ______________________

Alt # 2 Name: ______________________ Relationship: ______________________

Address: ______________________ Home Phone: (__) ______________________

Cell Phone :(__) ______________________ Work Phone : (__) ______________________

Alt # 3 Name: ______________________ Relationship: ______________________

Address: ______________________ Home Phone: (__) ______________________

Cell Phone :(__) ______________________ Work Phone : (__) ______________________

FAMILY INFORMATION:

Student is living with:

___ Both Parents ___ Father ___ Mother ___ Guardian ___ Step-Parent ___ Other ___ Foster Parent

Parents are: ___ Married ___ Divorced ___ Separated ___ Never Married ___ Widowed

Student and family who have temporary living arrangements:

____ Shelter _____Unsheltered _____Shared Housing _____Hotel/Motel

If there is a court custody order pertaining to this child, who has custody? ______________________

(A copy of custody papers is REQUIRED to be on file).

PART I OR II MUST BE COMPLETED.

NOTE: NO ONE will be permitted to pick up your child unless his/her name appears on this form, or we have written confirmation from Parent or Guardian. **This includes an evacuation or terrorist alert.**

PART I: TO GRANT CONSENT

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

Physician ____________________ Telephone (___) ____________

Dentist ____________________ Telephone (___) ____________

Medical Specialist ____________________ 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 opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.
Please give facts concerning the student's medical history, including allergies and medications being taken:

Medical condition(s) we should be made aware of ____________________

____

Medicine student is currently taking (amount/when taken) ____________________

____

Allergies ____________________

____

Any other needed information regarding student ____________________

____

____

Date ____________ Signature of Parent/Guardian ____________________

NOTE: This information will be shared with staff who have a legitimate educational need to know.

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent(s) are contacted and the instructions on this form are followed. In extreme emergencies, arrangements may be made for a student's immediate hospitalization whether or not the parent(s) can be reached. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

____

Date ____________ Signature of Parent/Guardian ____________________