

School – Emergency Medical Authorization Form – APS

Student Name: _____

Student ID: _____

Please check the following data – if data are incorrect, please cross out and update using RED INK, Thank you.

Student: _____ Birth Date: ____/____/____ Grade: _____ Room#: _____
Address: _____ Phone: _____

**** Please list the parents or responsible person(s) who may be contacted and/or permitted to take the child from school in case of emergency:

	<u>Contact</u>	<u>Relationship</u>	<u>Home Phone</u>	<u>Work Phone/ext</u>	<u>Cell/Pager</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Allergies: _____

Medication: _____

Physical Impairments: _____

Preferred Physician: _____ Phone: _____ Preferred Hospital: _____

Preferred Dentist: _____ Phone: _____

Preferred Mental Health Specialist: _____ Phone: _____

Comments: _____

EMERGENCY DISMISSAL: If any emergency situation forces school to close before regular dismissal time, closing will be announced over local media. If there is an emergency dismissal, my child: () can walk or be sent home on the regular school bus, () will be picked up at school as soon as possible, () must remain at school until regular dismissal time.

PURPOSE – To all authorize treatment for a child who becomes ill or injured or in need of mental health emergency services while under school authority, when parents cannot be reached, in the event reasonable attempts to contact me or other parents (at the above numbers) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred physician, preferred dentist or preferred mental health specialist (named above), or in the event, the designated preferred practitioner is not available, by another licensed physician, dentist or mental specialist, and (2) the transfer of the child to preferred hospital or emergency care facility of 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 before surgery is performed.

Please complete the following and sign:

_____ I do give my consent for emergency medical, dental or mental health treatment of my child.

_____ I do NOT give consent for emergency medical treatment of my child. in the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

Date: _____ Signature of Parent or Guardian: _____

Please return to school by no later than: _____