MILLER CITY-NEW CLEVELAND

LOCAL SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION FORM

PHONE: 419-876-3173 419-876-3174 FAX: 419-876-2020

Student Name: _____ Grade: _____

Address: _____

Home Phone: _____ Date of Birth: _____

Mother: _____ Work Phone: _____ Cell Phone: _____

Father: _____ Work Phone: _____ Cell Phone: _____

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be contacted.

Primary Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Secondary Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Alternate Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent Email: _____

FIELD TRIP PERMIT

_____Has my permission to go with a school chaperoned group on field trips away from the building.

_____

Signature of Parent/Guardian Date

PUBLICITY PERMIT/CLASS ROSTER

The Miller City-New Cleveland Schools have permission to use my child's name and photograph in any school related news release to local and area newspapers, the school's webpage, as well as Miller City-New Cleveland School Facebook page, and to make available, upon request, student directory information.

_____

Signature of Parent/Guardian Date

PART I: TO GRANT CONSENT

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

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room Phone: _____

In the event reasonable attempt to contact me has 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.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Date_____ Signature of Parent/Guardian _____

Address _____

City Zip

PART II REFUSAL TO CONSENT

I do **NOT** give my 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 the following action:

_____

_____

Date_____ Signature of Parent/Guardian _____

Address _____

City Zip

*****EARLY DISMISSAL*** (elementary/middle school)**

In the case of an early dismissal, my child _____ should

____follow their normal procedures for drop off

____be dropped off at _____ Bus # _____

Parent Signature _____