THE BRIDGEPORT SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION FORM

Student I.D. ________________ Date of Birth ______________ Grade ________

Student Name ____
Address____City_________________State________ Zip ____________
Telephone ( ) _________________________

The purpose of this form: To enable parents/guardians to authorize provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians cannot be reached. Please list additional authorized (**Adult**) individuals on the back of this form: State Name, Relationship, and Telephone Number. Photo identification must be shown when signing out and picking up student.

Residential Parent or Guardian

Mothers Name	**First Name**	**Last Name**	**Daytime Phone**	**Cell Phone**
Fathers Name	**First Name**	**Last Name**	**Daytime Phone**	**Cell Phone**
Other's Name	**First Name**	**Last Name**	**Daytime Phone**	**Cell Phone**

Relative or Childcare Provider:

Name ____ Relationship _______________________
Address ____ Daytime Phone ( ) ______________
City ____State _____________ Zip ___________

Part 1: To Grant Consent

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

Physician		**Phone Number**	( )
Dentist		**Phone Number**	( )
Medical Specialist		**Phone Number**	( )
Local Hospital		**Emergency Room**	( )

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)** 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 dentist, 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:

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Date ______________ Signature of Parent/Guardian _______________________________________
Address _____________________________________ 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:

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Date ______________ Signature of Parent/Guardian _______________________________________
Address _____________________________________ Zip ________________________

	Name	Relationship	Phone Number
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