WEST CARROLLTON SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM
Complete all areas in black ink. Press HARD.

Student Information **BUS#:**

Date of Birth: ___________ Grade: _____ Gender: M F Student name: ____

Teacher: ______________________ Building: _____________________________ Home Phone: _________________________

Address: ____ City: ____________________________ Zip: ____________

PLEASE INDICATE IF LISTING STEP-PARENTS.

Mother's Name: __________________________________ Father's Name: ____________________________________

Mother's Address: ________________________________ Father's Address: __________________________________

____ ____

City: ________________ State: ______ Zip: __________ City: __________________ State: _____ Zip: __________

Home #: _______________ Cell #: __________________ Home #: _______________ Cell #: ___________________

Mother's Email: ________________@_______________ Father's Email: ___________________@______________

Employer: _______________ Work #: ________________ Employer: _______________ Work #: ________________

Emergency contacts we may release your child to: (will call in order if parent/guardian **CAN NOT** be reached)

1. Name: ______________________________ Relationship: ______________ Phone: ______________ Cell: _______________
2. Name: ______________________________ Relationship: ______________ Phone: ______________ Cell: _______________

HEALTH INFORMATION—LIST HEALTH INFORMATION SCHOOL PERSONNEL SHOULD BE AWARE OF:

Allergies: No ____ Yes ____ Specify ______________________________________(***Food allergy requires doctor statement)***

Epi-pen: No ____ Yes ____ ***If yes, Epi-pen Medication Authorization Form must be completed.***

Asthma: No ____ Yes ____ ***If yes, Inhaler Medication Authorization Form must be completed.***

Seizures: No ____ Yes ____ Name(s) of seizure medications? ____

Diabetes: No ____ Yes ____ Name(s) of diabetic medications? ____

Does your student take any medication regularly? No ____ Yes ____ Specify ________________________________

Will your student take medication at school? No ____ Yes ____ ***If yes, Medication Authorization Form must be completed.***

Are there any other medical conditions that school personnel should be aware of? ____________________________

CONSENT

I **DO GIVE PERMISSION** for emergency treatment of my child, if a parent/guardian cannot be reached. This permission does not cover major surgery, unless the medical opinions of two licensed physicians or dentists concur prior to the performance of such surgery.

Parent/Guardian signature ____ **Date** ____________________________

Preferred Doctor ____Phone______________________

Preferred Hospital ____ Phone______________________

Preferred Dentist ____Phone______________________

REFUSAL

I **DO NOT GIVE PERMISSION** for emergency treatment of my child. In the event my child needs emergency treatment, I wish the school authorities to take the following action: ____

____

Parent/Guardian signature ____ Date ________________________

Rev. 1/10/2012