

**CONTINENTAL HIGH SCHOOL -- 2018-2019  
EMERGENCY MEDICAL AUTHORIZATION**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Locker \_\_\_\_\_

Home/Primary Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Bus #/Driver \_\_\_\_\_

Street Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Student resides with (circle all that apply)      Mother                  Father                  Stepparent                  Guardian  
Other, list relationship \_\_\_\_\_

Who has legal custody? \_\_\_\_\_

Court custody order: Yes  No  If yes, court papers submitted to the school office: Yes  No

Mother's Information	
Name	_____
Address	_____
City	_____ Zip _____
Email	_____
Home Phone	_____
Cell Phone	_____
Work/Daytime Phone	_____
Employer	_____

Father's Information	
Name	_____
Address	_____
City	_____ Zip _____
Email	_____
Home Phone	_____
Cell Phone	_____
Work/Daytime Phone	_____
Employer	_____

Guardian's Information	
Name	_____
Address	_____
City	_____ Zip _____
Email	_____
Home Phone	_____
Cell Phone	_____
Work/Daytime Phone	_____
Employer	_____

Other's Information	
Name	_____
Address	_____
City	_____ Zip _____
Email	_____
Home Phone	_____
Cell Phone	_____
Work/Daytime Phone	_____
Employer	_____

Relative or Childcare Provider to be contacted in the event parents cannot be reached when the child is ill or requires transportation from school. Please list three.

Name	Relationship	Phone Numbers
1st _____		
2nd _____		
3rd _____		

**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 Continental Local Schools have permission to use my child's name and photograph in any school related news release to local and area newspapers and to make available upon request student directory information.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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

## **PART I OR II MUST BE COMPLETED**

### **PART I - TO GRANT CONSENT**

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

Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Medical Specialst \_\_\_\_\_ Phone \_\_\_\_\_  
Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

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 doctor, 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, medication being taken, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

### **DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

### **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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_