BETHANY EMERGENCY MEDICAL AUTHORIZATION

Student ____ Homeroom _____
(Last) (First) (Middle Initial)

Birth Date ________________ Email addresses ________________________________

Street ________________________________City/State________________ Zip________

Mother's Name ____________________________ Home #______________Cell #____________

Mother's place of employment ________________________________ Work #____________

Father's Name ____________________________ Home #______________Cell #____________

Father's place of employment ________________________________ Work #____________

Names and grades of brothers and sisters____

Since the care and treatment of the student is primarily the responsibility of the parent, every effort will be made to contact the parent first.

Please list all persons who can be contacted regarding student's care in the event a parent cannot be located.

Only those listed below will be permitted to pick up your child .

Place an (L) behind the name of any person authorized for Latchkey pick up ONLY.

Name ____________________________ Relation ____________ Cell # __________ Work #_________

Name ____________________________ Relation ____________ Cell # __________ Work #_________

Name ____________________________ Relation ____________ Cell # __________ Work #_________

Name ____________________________ Relation ____________ Cell # __________ Work #_________

Name ____________________________ Relation ____________ Cell # __________ Work #_________

Name ____________________________ Relation ____________ Cell # __________ Work #_________

List anyone who is **NOT PERMITTED** to visit/pick up your child from school:

Name ________________________________Name________________________________

*******PLEASE COMPLETE HEALTH INFORMATION QUESTIONNAIRE**
AND
CONSENT FOR TREATMENT ON BACK******

HEALTH INFORMATION - Student Name____
(Last) (First)

List any **health conditions** that your child has:____

List any **medications** that your child takes:

At home: ____

At School:____

List any **allergies** that your child has and what treatment is needed for reactions.

Medication Alllergies ____

Food Allergies ____

Environmental allergies____

Insect/Bee Allergies ____

Has your child traveled outside the United States in the past year? _____ No _____ Yes If so,Where? ____________________

PART I <u>OR</u> PART II MUST BE COMPLETED

PART I 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____ Phone__________________________

In the event reasonable attempts to reach 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. 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 the surgery, are obtained prior to the performance of such surgery.

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__________________State _______ Zip__________