# EMERGENCY MEDICAL AUTHORIZATION FORM

| Student's Last Name | Student's First Name | Student's Middle Name | Birthdate | Grade |
|---|---|---|---|---|
| | | | | |

| Student's Home Address | City, State, Zip | Parent's Email |
|---|---|---|
| | | |

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

**Parent/Guardian gives KCCC permission to contact the following:**

| RELATIONSHIP | NAME | HOME PHONE | CELL PHONE | WORK PHONE | EMPLOYER |
|---|---|---|---|---|---|
| Mother/Guardian | | | | | |
| ***Mother/Guardian Address*** **(if different from student):** | | | | | |
| Father/Guardian | | | | | |
| ***Father/Guardian Address*** **(if different from student):** | | | | | |
| Stepmother | | | | | |
| Stepfather | | | | | |
| Foster Parent | | | | | |
| **In the event that the above contacts cannot be reached, list two people to whom you authorize the school to release your ill or injured child:** | | | | | |
| | | | | | |
| | | | | | |

**If not living with BOTH Parents - Legal Custodian or Residential Parent for School Placement:** _____

**Circle One:**
**Student Lives** Both Parents | Mother Only | Father Only | Guardian/Foster/Host | Grandparent | Mother-Stepfather | Father-Stepmother | Self

## EMERGENCY MEDICAL AUTHORIZATION - Part 1 OR Part II below must be completed.

### CONSENT FOR TREATMENT

I hereby give consent for the medical care providers and local hospital to be called. In the event reasonable attempts to contact me or the other parent have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the 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.

**Preferred Physician:** _____
Office Number: _____
**Preferred Dentist:** _____
Office Number: _____
**Medical Specialist:** _____
Office Number: _____
**Preferred Hospital:** _____
ER Number:

### *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:

_____
_____
_____

Parent/Guardian Signature: _____
Address: _____
_____

Date: _____

**MEDICAL HISTORY:** Facts concerning the child's medical history including allergies, medications being taken, date of last tetanus shot, and any physical impairment of which a physician and/or school personnel should be alerted.

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