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.

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

Parent/Guardian gives KCCC permission to contact the following:

RELATIONSHIP	NAME	HOME PHONE	PERMISSIONS
Mother/Guardian		Home #: ( ) _____-_____ Cell #: ( ) _____-_____ Work #: ( ) _____-_____ Employer: _____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No** Has Legal Custody: **Yes** **No** ***If Yes, must provide documents***

Mother/Guardian Address **(if different from student):**

Father/Guardian		Home #: ( ) _____-_____ Cell #: ( ) _____-_____ Work #: ( ) _____-_____ Employer: _____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No** Has Legal Custody: **Yes** **No** ***If Yes, must provide documents***

Father/Guardian Address **(if different from student):**

Step Mother		Phone #: ( ) _____-_____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No**
Step Father		Phone #: ( ) _____-_____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No**
Other: _____		Phone #: ( ) _____-_____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No**
Other: _____		Phone #: ( ) _____-_____	Emergency Contact: **Yes** **No** Can Pick-Up Student: **Yes** **No**

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: _____ Phone #: _____

Preferred Dentist: _____ Phone #: _____

Medical Specialist: _____ Phone #: _____

Preferred Hospital: _____ ER Number: _____

Parent/Guardian Signature: _____ **Date:** _____

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.