EMERGENCY MEDICAL AUTHORIZATION
MANSFIELD CITY SCHOOLS

Student's Social Security Number | Student's Name

Grade | Home Room | Student ID# | Address | Zip Code

Date of Birth | Home Telephone #

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

PART 1 OR 2 MUST BE COMPLETED

Part 1 – To Grant Consent:

Parent or Guardian | Relationship | Telephone #

E-Mail Address | Cell Phone or Pager #

Address (If different) | Place of Employment | Telephone #

Spouse's Name | Spouse's Place of Employment | Telephone #

IN THE EVENT I CANNOT BE REACHED, THE SCHOOL HAS MY PERMISSION TO RELEASE MY CHILD TO THE NAMES LISTED BELOW ONLY. A PICTURE I.D. MAY BE REQUIRED BEFORE THE STUDENT WILL BE RELEASED! NO EXCEPTIONS!

1. Name | Telephone #

2. Name | Telephone #

3. Name | Telephone #

4. Name | Telephone #

Doctor to be called | Telephone #

Dentist to be called | Telephone #

Health Insurance Company

Insurance Group Number

FACTS CONCERNING THE CHILD'S HISTORY WHICH A PHYSICIAN SHOULD BE ALERTED:

Does the Child Have (Check all that apply):

___ ADHD ___ Cancer ___ Behavior Concerns ___ Mental Health Issues
___ Asthma ___ Immune Disorder ___ Migraine Headaches ___ Seasonal Allergies/Hay Fever
___ Diabetes ___ Seizures ___ Heart Condition ___ Blood or Metabolic Disorder

___ Other Serious Medical Condition _____

Explain any items checked above: _____

Medication allergies or other allergies: _____

Current medications student takes: _____

I authorize designated school personnel to provide first aid and comfort measures to my child including cough drops, sting relief, triple antibiotic ointment, peroxide, antifungal cream, Tums, anbesol for toothache, burn relief gel, caladryl lotion, salt water gargle, saline eye drops or contact solution, and Tylenol (for Middle and High School students only.

I understand that the school nurse ensures free health screenings are completed including height, weight, vision, hearing, scoliosis as required by law, and that I will be notified of any abnormal findings.

I understand that all over-the-counter and prescription medications sent from home must be accompanied by proper parent/guardian consent and physician's orders and taken to the school nurse by the parent for proper storage and administration. Students are not to carry or share any medications with another student.

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 designed preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the child to MedCentral Hospital. 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.

Parent/Guardian's Signature | Date

Part 2 – Refusal to Consent

I do **NOT** give my consent to emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

_____

Parent/Guardian's Signature | Date

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