GENEVA AREA CITY SCHOOLS - EMERGENCY MEDICAL AUTHORIZATION FORM

Date: _____ DOB: _____ Grade: _____ New Address ☐

Student Name: _____ Student Cell Phone: _____

Street Address: _____ Mailing Address: _____

City: _____ Zip: _____ Phone for Robo-Call: _____

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.

Please list parents/guardians & individuals who have your permission to be called and/or pick up your child in the event of illness/emergency

Student is living with: Both Parents Biological Mother Biological Father Legal Guardian Grandparent(s) Other
(circle one)

Mother, Step-Mother, or Guardian's Name: _____ Home Phone: _____

Address: _____ Cell. Phone: _____

Place of Employment _____ Bus. Phone: _____ OK to Call at Work? Y N

E-Mail Address: _____ Authorized to transport and make decisions for this child? ☐ Yes

Father, Step-Father, or Guardian's Name:___ Home Phone: _____

Address: _____ Cell. Phone: _____

Place of Employment _____ Bus. Phone: _____ OK to Call at Work? Y N

E-Mail Address: _____ Authorized to transport and make decisions for this child? ☐ Yes

In the event we cannot reach you by phone, please provide the name and number of an alternate person to contact in case of illness or an emergency at school.
Name: _____ Address: _____ Relationship: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Military Status (If applicable): ☐Mother ☐Father ☐ Active ☐ Inactive ☐ Guard ☐Reserve ☐ NA	Military Branch: ☐Army ☐AF ☐Marines ☐Navy ☐C.Guard
Military Status (If applicable): ☐Mother ☐Father ☐ Active ☐ Inactive ☐ Guard ☐Reserve ☐ NA	Military Branch: ☐Army ☐AF ☐Marines ☐Navy ☐C.Guard

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: _____Address _____ Phone: _____

Dentist: _____Address _____ Phone: _____

Medical Specialist: _____Address _____ Phone: _____

Local Hospital: _____Address _____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 reasonable 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, medications, taken, and any physical impairments to which a physician should be alerted. ***Health Conditions (Check Box)*** **☐Asthma ☐ Diabetes ☐ Bee Sting Allergy ☐ Seizures ☐ Food/Medication Allergies ☐ Other?** (list) _____

Date: _____ Signature of Parent/Guardian_____

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: _____