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.

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

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

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: ____