

BRIDGES COMMUNITY ACADEMY EMERGENCY MEDICAL AUTHORIZATION

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 parent or guardians cannot be reached.

Student's Information

Name _____ Gender _____
Home Phone # _____ Grade Level _____ Date of Birth _____
Address _____
Street _____ City _____ State _____ Zip Code _____

Father's Information

Name _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____
Address (if different than student) _____
E-mail address _____
Step Mother's Name _____ Step Mother's Work Number _____

Mother's Information

Name _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____
Address (if different than student) _____
E-mail address _____
Step Father's Name _____ Step Father's Work Number _____

Guardian's Information (if other than parents)

Name _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____
Address (if different than student) _____
E-mail address _____

Others to Reach

Person(s) who may be notified, and to whom your child may be released if the school fails to reach you.

1. Name _____ Relationship _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____
2. Name _____ Relationship _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____
3. Name _____ Relationship _____
Work Phone _____ Home Phone _____ Cell Phone /Pager _____

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you do not consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Medical Problems/Allergies/Special Needs:

Diabetes Asthma Seizures Bee or Insect Sting
 Orthopedic Visually or Hearing Impaired Medication or Food Allergy
 Emotional Problem Learning Disability Other

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Preferred Hospital _____ City _____

EMERGENCY ROOM PHONE _____

PART 1-TO GRANT CONSENT

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 reasonably accessible. This authorization does not cover major surgery unless the **medical** opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Signature of Parent /Guardian _____ Date _____

PART 2- TO REFUSE 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 NO action or to:

Signature of Parent /Guardian _____ Date _____