EMERGENCY MEDICAL
AND TRANSPORTATION 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, and to designate alternate contacts/transportation when parents or guardians cannot be reached.

Family Name: ________________________ **Primary Email:** ________________________

Grade ________ Student's Name ________________________ Gender ____________

Date of Birth____________ Address ________________________

Bus # _________ Drop-Point Address ________________ Home Phone/area code (_____) ____________

Child lives with: ☐ Mother ☐ Father ☐ Step-father ☐ Step-mother ☐ Other

Mother's (Guardian) Name: ________________________

Address: ________________________

Home Phone: ____________________ Cell Phone: ____________________

Employer's Name: ____________________ Phone: ____________________

Address: ________________________

Father's (Guardian) Name: ________________________

Address: ________________________

Phone: ____________________ Cell Phone: ____________________

Employer's Name: ____________________ Phone: ____________________

Address: ________________________

Please select all that apply: ☐ Both parents are authorized to pick-up student ☐ Mother Only ☐ Father Only

In case of early dismissal for inclement weather or emergency situations, every attempt will be made to contact parent or emergency contact. If this is not possible, I request that you: *(please check one below)*

☐ Send my child(ren) home on the bus ☐ Send my child(ren) to Extended Day Program

Please list Alternate Contacts (other than parent/guardian) in the event of emergency, illness, etc. if parents cannot be reached:

Name: ________________________ Relationship to child____________

Address: ________________________ Phone: ____________________

Name: ________________________ Relationship to child____________

Address: ________________________ Phone: ____________________

SECTION 1 OR 2 MUST BE COMPLETED ON THE REVERSE SIDE.

**** ALONG WITH FACTS CONCERNING CHILD'S MEDICAL HISTORY ****

**** IMPORTANT - PLEASE COMPLETE THIS SECTION ****

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

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COMPLETE EITHER SECTION 1 OR 2 BELOW. ***DO NOT COMPLETE BOTH.***

SECTION 1: Permission to treat/transport child: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by doctor named or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to any hospital reasonably accessible. Include all phone numbers.
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.

I give ____ _____permission to treat or
Name of school

transport my child ____to:
Name of Child

Doctor____Phone______________________________

Address____

Dentist____Phone______________________________

Address____

Medical Specialist___________________________________Phone______________________________

Address____

Local Hospital Emergency Room____

Address____Phone______________________________

Parent's Signature: ____Date:_______________

SECTION 2: Refusal to grant permission to treat/transport child:

I do not give permission to ____
Name of school

For emergency medical treatment of my child ____
Name of Child

**In the event of illness/injury which requires emergency medical/dental treatment, I wish the following actions to be taken:

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Parent's Signature: ____Date:_______________