EMERGENCY MEDICAL AUTHORIZATION
MIDDLETOWN CHRISTIAN SCHOOLS

This form is to be completed annually by parent/guardian ONLY. Please notify school of any changes in this information throughout the school year
This Emergency Medical Authorization, required by State Law, must be on file for each student.

Student's Name _____ Birthdate _____ Home Telephone (____) _____ Grade/Teacher _____

Address _____ City _____ School _____ Social Security Number _____

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 complete and return as quickly as possible.

Full name of children in school building:

1. _____ Name _____ Grade
2. _____ Name _____ Grade
3. _____ Name _____ Grade
4. _____ Name _____ Grade

PART I OR II MUST BE COMPLETED (PART I TO GRANT CONSENT)

_____ Father/Guardian _____ Place of Employment (____) _____ Work Number/Ext. (____) _____ Cell Number

_____ Mother/Guardian _____ Place of Employment (____) _____ Work Number/Ext. (____) _____ Cell Number

In the event reasonable attempts to contact me failed, call: _____ at (___) _____
(Other parent/guardian phones)

If contacting me has been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (Preferred physician) at (____) _____ or Dr. _____ (Preferred dentist) at (____) _____ 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 _____ (Preferred hospital) at (____) _____ or any hospital reasonably 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. In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.

CHILD PICK-UP/EMERGENCIES: I AGREE THAT THE SCHOOL MAY RELEASE MY CHILD TO THE FOLLOWING PEOPLE AND PROVIDE PERTINENT INFORMATION RELATED TO THIS RELEASE.

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED OR ARE NOT AT HOME. IN CASE OF INCLEMENT WEATHER SUCH AS SNOW, EXTREME HEAT, OR EMERGENCY POWER FAILURE, LIST TWO NAMES OF PEOPLE YOU HAVE MADE ARRANGEMENTS WITH FOR YOUR CHILD TO STAY WITH IF SCHOOL DISMISSES EARLY.

1. Name _____ Relationship _____ Address _____ Ph. #( ) _____
2. Name _____ Relationship _____ Address _____ Ph. #( ) _____
3. Name _____ Relationship _____ Address _____ Ph. #( ) _____
4. Name _____ Neighbor _____ Address _____ Ph. #( ) _____
5. Name _____ Neighbor _____ Address _____ Ph. #( ) _____

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

_____

_____

Date _____ Signature of Parent/Guardian _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
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 no action or to: _____

_____

Date _____ Signature of Parent/Guardian _____