

# EMERGENCY MEDICAL AUTHORIZATION FORM

**PURPOSE:** To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

Last Name:  First Name:  MI:  Gender:  Date of Birth:  Age:  Grade:  Teacher:

Home Address:  Zip Code:  Home Phone #:  Ever attended RRPS?  Yes  No

(House Number & Street Name) (Ave, Blvd, Cir, Ct, Dr, Hwy, Ln, Loop, Pl, Rd, St, Tr, Way) (NE, SE, NW, SW)

School Last Attended (Name, City, State)  Ethnicity (optional)  Asian  Black  Caucasian/White  Hispanic  American Indian  Other

**Parent/Guardian Information**

Mother's/Guardian's Name:  Living with this person?  Yes  No Legal Guardian?  Yes  No Mother's/Guardian's Home Address: (If different from above.)

Mother's/Guardian's Employer:  Home Phone:  Work Phone:  Cell Phone:  E-mail address:

Father's/Guardian's Name:  Living with this person?  Yes  No Legal Guardian?  Yes  No Father's/Guardian's Home Address: (If different from above.)

Father's/Guardian's Employer:  Home Phone:  Work Phone:  Cell Phone:  E-mail address:

Name of person with whom student lives. (if other than above)  Relationship:  Legal Guardian:  Yes  No Person's Home Address:

Person's Employer:  Home Phone:  Work Phone:  Cell Phone:  E-mail address:

**Emergency Contact Information (Please list by priority):**

Name:	Relationship:	Phone #1:	Phone #2:

**Siblings:** (Name of all children (under 18) living at this address. If under 5 and attending pre-school, please give the name of the pre-school.)

Name:	School:	Grade:	Date of Birth:

**INSURANCE INFORMATION**

Student's Insurance (primary)  Subscriber's Name  ID#

**TO GRANT CONSENT**

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospitals to give any reasonable and customary medical and health care deemed necessary:

Physician/Nurse Practitioner or Physician Assistant  Phone ( )

Dentist  Phone ( )  Hospital  Phone ( )

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

I authorize the school nurse to contact my child's physician/healthcare provider regarding medical management of my child.

Signature of Parent/Guardian  Date

