

**NORTH UNION LOCAL SCHOOL DISTRICT
EMERGENCY INFORMATION & MEDICAL AUTHORIZATION**

**PLEASE USE BALLPOINT PEN
PRESS FIRMLY**

Student I.D. # _____
Social Security # _____

Student's Name _____ Grade _____
(Last) (First)

Home Address _____ Birth date _____
City _____ Zip Code _____ Teacher _____
Home Telephone Number _____ Bus#/Driver _____

Student Resides with: Mother Father Both Stepmother Stepfather Other: _____

If your child is injured we need the following information: HOME:

Email _____
Mother: _____ Business Telephone _____
Pager _____ (Business Name)
Cell Phone _____
(Business Address)

Father: _____ Business Telephone _____
Pager _____ (Business Name)
Cell Phone _____
(Business Address)

List relatives or neighbors who will know your whereabouts and assume temporary care of your child if you cannot be reached. (List in order you wish for us to call)

- 1) Name: _____ Address: _____ Telephone: _____
2) Name: _____ Address: _____ Telephone: _____
3) Name: _____ Address: _____ Telephone: _____

*If school is dismissed early due to an emergency, my child should go home or local address of:

Purpose of the following information: 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. Fill out only Part 1 or Part 2.

PART I – GRANTING CONSENT

In the event reasonable attempts to contact me at (Tel. No.) _____ have been unsuccessful, I hereby give consent for:
(1) the administration of any treatment deemed necessary by (Physician) Dr. _____ at (Tel. No.) _____
_____ or (Dentist) Dr. _____ at (Tel. No.) _____, 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)
_____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options 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 being taken, and any physical impairments to which a physician should be alerted:

Date: _____ Sig. of Parent or 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 no action but to do the following:

Date _____ Sig. Of Parent or Guardian _____

PLEASE FILL IN EACH LINE!!!!

PLEASE FILL IN EACH LINE!!!!