MADISON-PLAINS LOCAL SCHOOL DISTRICT EMERGENCY MEDICAL FORM

Student Name ____ Date of Birth _______________

Street Address ____City/State/Zip______________________

Home Phone___________________ Grade__________ Sport _________________________

Child lives with ___Father ___Step-father ___Foster Parent ___Guardian Home Phone _________________

Name ____ Cell Phone _____________________________

Employer ____ Employer Phone ___________________

Child lives with ___Mother ___Step-mother ___Foster Parent ___Guardian Home Phone ________________

Name ____ Cell Phone _____________________________

Employer ____ Employer Phone __________________

It is imperative that you list two family members or friends able to assume temporary care of your child in case you are unavailable during school hours.

Name _______________________________
Phone______________ Cell ______________
Relationship ___________________________

Name__________________________________
Phone _______________ Cell _______________
Relationship _____________________________

PERMISSION TO RIDE TO AND FROM SCHOOL: My son/daughter has my permission to ride to and from school with other Madison-Plains Students:
Parent/Guardian Signature ____ Date: ______________

PART I – GRANT REQUEST: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

In the event reasonable attempts to contact me at: ______________________________ (phone number) or ___________________ (other parent) at ____________________________ (phone number) have been unsuccessful, I hereby give my consent for 1. The administration of any treatment deemed necessary by:

Dr. ____ (preferred physician) PHONE __________________
Dr. ____ (preferred dentist) PHONE __________________
or, in the event that designated preferred practitioner is not available, by another licensed physician or dentist; and 2. The transfer of the child to Madison County Hospital. 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 before surgery is performed. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physical impairments to which a physician should be alerted: ____
____

____ _____________________
Signature of Parent/Guardian Date

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, I wish the school to take the alternative procedures**:** ______________________________________
____

____ ____________________
Signature of Parent/Guardian Date