

EMERGENCY MEDICAL AUTHORIZATION FORM

Lancaster City Schools

Has Home/Phone Info changed in the past year? Yes No

Please complete in BLUE OR BLACK INK

School _____ Student's Name _____

Teacher/Grade _____ Street _____

Date of Birth _____ City _____ Zip _____

Home Phone# _____ Mother's Cell # _____ Father's Cell # _____

Purpose -- To enable parents, guardians, alternate persons listed below, to authorize the provision of emergency treatment, including the administration of medication, for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name: _____ Place of Employment: _____
Work Phone (____) _____
First Last
Lives with student: Yes No
Ok to contact at work: Yes No

Father's Name: _____ Place of Employment: _____
Work Phone (____) _____
First Last
Lives with student: Yes No
Ok to contact at work: Yes No

Guardian's Name: _____ Place of Employment: _____
Work Phone (____) _____
First Last
Lives with student: Yes No
Ok to contact at work: Yes No

Alternate Persons to Notify:

Alt # 1 Name: _____ Relationship: _____
Address: _____ Home Phone: (____) _____
Cell Phone :(____) _____ Work Phone : (____) _____

Alt # 2 Name: _____ Relationship: _____
Address: _____ Home Phone: (____) _____
Cell Phone :(____) _____ Work Phone : (____) _____

Alt # 3 Name: _____ Relationship: _____
Address: _____ Home Phone: (____) _____
Cell Phone :(____) _____ Work Phone : (____) _____

FAMILY INFORMATION:

Student is living with:

____ Both Parents ____ Father ____ Mother ____ Guardian ____ Step-Parent ____ Other ____ Foster Parent

Parents are: ____ Married ____ Divorced ____ Separated ____ Never Married ____ Widowed

Student and family who have temporary living arrangements:

____ Shelter ____ Unsheltered ____ Shared Housing ____ Hotel/Motel

If there is a court custody order pertaining to this child, who has custody? _____
(A copy of custody papers is **REQUIRED** to be on file).

PART I OR II MUST BE COMPLETED.

NOTE: NO ONE will be permitted to pick up your child unless his/her name appears on this form, or we have written confirmation from Parent or Guardian. **This includes an evacuation or terrorist alert.**

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Telephone (____) _____
Dentist _____ Telephone (____) _____
Medical Specialist _____ Telephone (____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors 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 any hospital reasonably accessible. During a medical emergency/disaster, the medical facility and Lancaster City Schools is authorized to release information to each other regarding students who have been transported to the facility for medical treatment.
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.
Please give facts concerning the student's medical history, including allergies and medications being taken:

Medical condition(s) we should be made aware of _____

Medicine student is currently taking (amount/when taken) _____

Allergies _____

Any other needed information regarding student _____

Date _____ Signature of Parent/Guardian _____

NOTE: This information will be shared with staff who have a legitimate educational need to know.

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent(s) are contacted and the instructions on this form are followed. In extreme emergencies, arrangements may be made for a student's immediate hospitalization whether or not the parent(s) can be reached. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____ Signature of Parent/Guardian _____