Springfield CITY SCHOOL DISTRICT
Every Student | Every Opportunity | Every Day

Emergency Medical Authorization

Purpose: To enable parents/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.

Student Information

Student Name: _____

Address: _____

Phone: _____ Student ID #: _____

Birthdate: _____ Male/Female: _____

School: _____ Current Grade: _____

PLEASE INDICATE IF YOUR CHILD HAS ANY OF THE FOLLOWING:

Allergies to medicine? ☐ Yes ☐ No
If yes, please list: _____

Allergies to food? ☐ Yes ☐ No
If yes, please list: _____

Environmental Allergies? ☐ Yes ☐ No
If yes, please list: _____

Does your child require medication on a regular basis? ☐ Yes ☐ No
If yes, please list: _____

Does your child require medication during school hours? ☐ Yes ☐ No
If yes, please list (including Inhalers): _____

Please Note: *If yes, medications are administered in compliance with the Board of Education policy JHCD. Form 0-35/0-35A Release for Administration of Medication, must be completed.*

Are there any medical concerns/conditions you feel may impact your child's performance at school? ☐ Yes ☐ No
If yes, please list: _____

Contact Information

Primary Contact: _____

Relationship: _____ Legal Guardian: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____

Please list two (2) additional people who may be contacted in the event of a medical emergency.
Please DO NOT re-list the parent/guardian.

Secondary Contact: _____

Relationship: _____ Legal Guardian: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____

Authorized to pick student up? ☐ Yes ☐ No

Other Contact: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Authorized to pick student up? ☐ Yes ☐ No

CONSENT: PART 1 or PART 2 MUST BE COMPLETED:

PART 1: ***I GRANT CONSENT FOR TREATMENT:***

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

Physician: _____ Phone: _____ Dentist: _____ Phone: _____

Specialist: _____ Phone: _____ Hospital: _____ Phone: _____

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 the above named doctor 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. 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.

Parent/Guardian Signature: _____ Date: _____

PART 2: ***REFUSAL TO GRANT 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 authority to take the following actions: _____

_____

Parent/Guardian Signature: _____ Date: _____