Emergency Medical Authorization Form
Paint Valley Local School District

Bus Number_____

School (check one) ____ Elementary ____ Middle School ___ High School Grade _____

Student _____ Date of Birth _____ Telephone _____
Address _____ P. O. _____

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/guardians cannot be reached.

Residential Parent/Guardian

Mother's Name _____ Home _____ Work _____ Cell _____
Father's Name _____ Home _____ Work _____ Cell _____
Other's Name _____ Home _____ Work _____ Cell _____

Name of Relative/Childcare Provider _____ Relationship _____
Address _____ Home _____ Cell _____

PERMISSION FOR OVER THE COUNTER MEDICATION

I give permission for my child to be given the following over the counter medications if needed, according to school policy.

___Tylenol ___Motrin/Ibuprofen ___Calamine lotion/Neosporin cream ___Benadryl ___Rolaids/Tums tablets

Signature of Parent/Guardian _____ Date: _____

*****Part I or Part II Must Be Completed Below*****

****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 _____
Preferred Hospital _____ 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 the 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 my child to any hospital reasonably accessible. **This authorization does not cover major surgery unless the medical opinions of two other licensed physicians/dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.**

Physical/medical conditions: _____

Allergies: _____ **Current Medications**: _____

_____

Date_____ Signature of Parent/Guardian _____
Address_____

****Part II**** **REFUSAL TO CONSENT:** I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness/injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

Date: _____ Signature of Parent/Guardian _____
Address_____

List brothers/sisters and grade level who attend Paint Valley Local School District: _____

_____