EMERGENCY MEDICAL AUTHORIZATION
MIDDLETOWN CHRISTIAN SCHOOL

This Emergency Medical Authorization, required by State Law, must be on file for each student.

Student's Name	Birthdate	Home Telephone	Grade/Teacher

Address	School	Social Security Number

Purpose: 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. Please complete and return as quickly as possible.

Full name of children in school building:

1. ______________________ Name ________ Grade
2. ______________________ Name ________ Grade
3. ______________________ Name ________ Grade
4. ______________________ Name ________ Grade

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

Father/Guardian	Place of Employment	Phone

Mother/Guardian	Place of Employment	Phone

In the event reasonable attempts to contact me failed, call: ______________________ ______________________
(Other parent/guardian phones)

If contacting me has been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ______________________ or Dr. ______________________
(Preferred physician) (Preferred dentist)
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 ______________________ or any hospital reasonably accessible.
(Preferred 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 prior to the performance of such surgery.

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED OR ARE NOT AT HOME. IN CASE OF INCLEMENT WEATHER SUCH AS SNOW, EXTREME HEAT, OR EMERGENCY POWER FAILURE, LIST TWO NAMES OF PEOPLE YOU HAVE MADE ARRANGEMENTS WITH FOR YOUR CHILD TO STAY WITH IF SCHOOL DISMISSES EARLY.

1. Name__________ Relationship __________ Address __________ Ph. #__________
2. Name__________ Relationship __________ Address __________ Ph. #__________
3. Name__________ Relationship __________ Address __________ Ph. #__________
4. Name__________ Relationship __________ Address __________ Ph. #__________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Date ______________________ Signature of Parent/Guardian ______________________

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 requiring emergency treatment, I wish the school authorities to take no action or to: ______________________

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Date ______________________ Signature of Parent/Guardian ______________________