Constellation Schools

The Right Choice for Parents and a Real Chance for Children

Emergency Medical Authorization Form

Student First & Last Name:	Student's Birth Date:
Home Room:	Grade:
Address:	
Phone:	County of Residence:

Purpose – To enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent(s) or guardian(s) cannot be reached.

Residential Parent (s)/Guardian(s):

Mother's Name:	Preferred Phone:
Father's Name:	Preferred Phone:
Guardian's Name:	Preferred Phone:
Guardian's Relationship to Student:	

Persons available during the school day to be contacted in the event that the parent/guardian may not be reached:

Contact 1:	Preferred Phone:
Relationship to Student:	
Contact 2:	Preferred Phone:
Relationship to Student:	
Contact 3:	Preferred Phone:
Relationship to Student:	

Facts Concerning your child's medical history: If the answer was Yes to any of the below questions, additional form(s) are required and will be provided to you by the school.

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Does your child have any allergies such as food, insect, medication, seasonal, environmental, etc?	☐ No	☐ Yes. Which allergies?
Does your student require an Epi Pen or Anaphylaxis Care Plan?	☐ No	☐ Yes
Does your child require an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms?	☐ No	☐ Yes
Does your child require diabetes management at school?	☐ No	☐ Yes
Does your child require medication during school hours?	☐ No	☐ Yes

GRANT TO CONSENT/REFUSE

Do you authorize the provision of emergency treatment for your student in the event they become ill or injured while under school authority when parents or guardians cannot be reached?

☐ **Yes, I hereby give consent** for the following medical care providers and local hospital to be called 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 doctor listed below, 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.

☐ **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 the following action:

Student's Doctor	**Doctor Phone Number**
Student's Medical Specialist	**Medical Specialist Phone Number**
Preferred Hospital/ER	**Hospital Phone Number**

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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_____

Parent/Guardian Signature **Date**