STOW MUNROE FALLS HIGH SCHOOL
EMERGENCY MEDICAL FORM

STUDENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOMEROOM _____
GRADE _____
BIRTH DATE _____
PLACE OF BIRTH
(CITY)_____ (STATE) _____
CELL PHONE _____

MOTHER'S NAME _____
Same address ___ yes ___ no
MOTHER'S PLACE OF EMPLOYMENT _____
EMAIL ADDRESS _____

HOME PHONE _____
CELL PHONE _____
WORK PHONE _____

FATHER'S NAME _____
Same address ___ yes ___ no
FATHER'S PLACE OF EMPLOYMENT _____
EMAIL ADDRESS _____

HOME PHONE _____
CELL PHONE _____
WORK PHONE _____

GUARDIAN (If different than parent) _____

ALTERNATE CONTACT:
NAME _____
RELATIONSHIP _____
PHONE _____

ALTERNATE CONTACT:
NAME _____
RELATIONSHIP _____
PHONE _____

MEDICAL ALERTS: _____

MEDICATIONS: _____

EMERGENCY MEDICAL AUTHORIZATION

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. Part I or Part II must be completed.

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number), or _____(other parent/guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____, physician/dentist, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____(hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. List facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted below.

_____

_____

Signature of Parent/Guardian _____ Date _____

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

_____

_____

Signature of Parent/Guardian _____ Date _____