Woodridge Local School District

Grade: _____

EMERGENCY MEDICAL AUTHORIZATION

School: _____ Student Name: _____

Address: _____

City: _____ Zip: _____

Telephone: _____

Email Address: _____

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.

Residential Parent or Guardian

Mother's Name:_____ Daytime Phone: _____

Father's Name:_____ Daytime Phone: _____

Other's Name: _____ Daytime Phone: _____

Relative(s) or Childcare Provider(s) (Persons who have your permission to pick up your student from school or grant permission for your student to leave school and provide home care if needed.)

_____ Relationship _____

Address _____ Phone _____

_____ Relationship _____

Address _____ Phone _____

_____ Relationship _____

Address _____ Phone _____

LIST MEDICAL CONDITIONS

Problems Recommendation for the School:

PART I OR II MUST BE COMPLETED

(See Reverse Side)

Emergency Medical Authorization (Continued)

PART I – TO GRANT CONSENT

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

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room 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 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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

_____

_____

Signature of Parent/Guardian: _____ _____
Date

Address: _____

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, instead I wish the school authorities to take the following action:

_____

_____

Signature of Parent/Guardian: _____ _____
Date

Address: _____

FIELD TRIP PERMISSION SLIP

My Child _____, has my permission to participate in all field trips scheduled for his/her class for the current school year. Teacher's Name: _____

(Your child will not be granted permission to participate in a field trip unless this card is on file in the principal's office. Phone approvals will <u>not</u> be accepted. You will be informed in advance of each field trip to be taken).

10/06
8/25/10