# PUPIL RELEASE - EMERGENCY PROCEDURE - MEDICAL AUTHORIZATION

**Student Information for CMS School Year:** 2017-2018 **Bus #** _____ **Grade/Homeroom #** 8-5

**Student's Last Name** _____ **First Name** _____ **Date of Birth** _____

**Custodial Parent/Guardian Name(s)** _____

**Address** _____ **Parent's E-mail** _____

_____ **Home/Cell Phone** _____

**Child Lives with** _____ **Relationship** _____

**Parent are:** _____ **Married** _____ **Divorced** _____ **Separated** _____ **Mother Deceased** _____ **Father Deceased**

**Father's Name** _____ **Mother's Name** _____

**Address** _____ **Address** _____

_____ _____

**Father's DAYTIME Phone #** _____ **Mother's DAYTIME Phone #** _____

**Employer** _____ **Employer** _____

**In case of emergency, illness or accident to the child named above, the school is authorized to proceed as indicated below. (Please number each item 1, 2, 3, etc., in order of desired action):**

**#** ____ **Contact Mother at phone listed above or** _____ **#** ____ **Take child to** _____ **Hospital**

**#** ____ **Contact Father at phone listed above or** _____ **#** ____ **Take child to any licensed physician**

**#** ____ **Contact Family Doctor** _____ **Phone** _____

**#** ____ **Contact Dentist** _____ **Phone** _____

**#** ____ **Other** _____

**If parent or guardian is unavailable, please designate below those individuals to whom your child may be released. These individuals may be contacted for child illness, early dismissal, or emergency:**

| Name | Relationship | Daytime Phone |
|---|---|---|
| | | |
| | | |
| | | |

## EMERGENCY MEDICAL TREATMENT AUTHORIZATION

**** Complete and "x" EITHER Part I - To Grant Consent OR Part II - Refusal to Consent ****

____ **PART I - Grant Consent: In the event reasonable attempts to contact me at phone #** _____ **or to contact** _____ **at phone #** _____ **have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the doctor or dentist listed above or, in the event the designated preferred practitioner is not available, by another licensed practitioner; and (2) the transfer of the child to the following Hospital** _____ **or 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 before surgery is performed.**

**Please list facts concerning the child's medical history including allergies (i.e. bee stings, medications, etc.), medications currently being taken, and any physical impairments to which a physician should be alerted:**

_____

**Signature of Parent/Guardian** _____ **Date** _____

****Do Not Complete the following Part II if you completed Part I above****

____ **PART II - Refusal to Grant Consent: I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to either take no action or t(** _____

**Signature of Parent/Guardian** _____ **Date** _____