

**ALEXANDER JR HIGH/HIGH SCHOOL
EMERGENCY MEDICAL AUTHORIZATION**

Student Name: _____ Date of Birth: _____ Grade: _____
Address: _____ Student's Cell Number: _____
City: _____ State: _____ Zip: _____

CONSENT: I give permission for my child to receive medical treatment as needed in the school health clinic.

_____ **Initial**

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at: Home Phone Number: _____

Mother's Name _____ Work No _____ Father's Name _____ Work No _____

E-Mail _____ Cell No _____ E-Mail _____ Cell No _____

have been unsuccessful I hereby give my consent for the (1) administration of any treatment deemed necessary by:

Preferred Doctor: _____ Phone No: _____

Preferred Dentist: _____ Phone No: _____

any certified/designated school employee or emergency response personnel in the event the designated preferred practitioner is not available and (2) transfer my child to:

Preferred Hospital: _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained **BEFORE** the surgery **IS PERFORMED**.

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

| | | |
|--------------------------|--------|----------------------------------|
| OTHER EMERGENCY NUMBERS: | _____ | _____ |
| | Number | Name and relationship to student |
| | _____ | _____ |
| | Number | Name and relationship to student |

| | | |
|-------|----------------------------|---------------------------|
| _____ | _____ | _____ |
| Date | Parent/Guardian Print Name | Parent/Guardian Signature |

Updated Ethnicity Information per United States Department of Education New Regulations Beginning July 1, 2010

Hispanic: Yes _____ (also choose appropriate ethnicity group) No _____

Ethnicity: for multiracial students, please mark the appropriate 2 ethnicity groups

| | | |
|---|---|-------------|
| _____ White | _____ Black or African American | _____ Asian |
| _____ American Indian or Alaskan Native | _____ Hawaiian Native or Other Pacific Islander | |

-----OR-----

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. However in a life threatening emergency the district will provide the appropriate emergency medical treatment deemed necessary.

| | |
|-------|---------------------------|
| _____ | _____ |
| Date | Parent/Guardian Signature |