

KENT CITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

This form is the school's only way of arranging emergency treatment for your child. Please help us help your child by filling out completely and legibly. If any information changes during the school year, please contact the school immediately.

Child's Name _____	School D H L W SMS RHS	Grade _____
Address _____	Parent/Guardian Name #1 _____	
	Parent/Guardian Name #2 _____	
Primary Phone Number _____	Home Cell (Circle One)	Date of Birth _____
Email Address(es) _____		
Medical Conditions: _____		
Allergies: _____		
Current Medications: _____		
<i>If medication is required to be administered during school hours, please download & complete medication form(s) at: kentschools.net/forms</i>		
Child resides with (circle all that apply): Mother Father Stepmother Stepfather Grandparent Guardian Other _____		
Other children residing in the home:		
Name _____	DOB _____	School _____ Grade _____
Name _____	DOB _____	School _____ Grade _____
Name _____	DOB _____	School _____ Grade _____
Name _____	DOB _____	School _____ Grade _____

In case of emergency, only those adults listed below will be contacted in order until someone has been reached.

Adult's Name	Relationship to Child	Daytime Phone Number	Number is at:
1 st _____	<u>Parent/Guardian</u>	_____	Home Work Cell
		_____	Home Work Cell
2 nd _____	_____	_____	Home Work Cell
		_____	Home Work Cell
3 rd _____	_____	_____	Home Work Cell
		_____	Home Work Cell
4 th _____	_____	_____	Home Work Cell
		_____	Home Work Cell

PLEASE COMPLETE THIS SECTION AND SIGN BELOW – FORM IS VALID ONLY WITH SIGNATURE!

CONSENT FOR TREATMENT:

In the event reasonable attempts to contact authorized persons above have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by my child's doctor(s) named 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.

Doctor _____	Phone Number: _____
Other Medical Specialist _____	_____
Dentist _____	_____
Preferred Local Hospital _____	_____

Please check ONE box and sign below:

I give consent for treatment as described above.

I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I want the school authorities to take the following action: _____

Signature of Custodial Parent/Guardian _____ Date _____