KENT CITY SCHOOLS
PRESCHOOL 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. *Please contact the school immediately if any of the information is changed.*

Child's Name______________________ **Date of Birth**______________________

Address______________________ **Mother's Name**______________________

______________________ **Father's Name**______________________

Home Telephone Number______________________ **Date of Last Tetanus**______________________

Email Address(es) ______________________ ______________________

Child resides with (circle all that apply)**: Mother Father Stepmother Stepfather Grandparent Guardian Other**__________

Medical History:

Facts concerning child's medical history, including allergies, medications being taken, and any physical impairment:

____

____

In case of an emergency, we will contact the individuals listed below until someone is reached:

	Adult's Name	Relationship to Child	Daytime Phone Number	Number is at:
1st	__________	__________	__________	Home Work Cell
	Address __________		__________	Home Work Cell
2nd	__________	__________	__________	Home Work Cell
	Address __________		__________	Home Work Cell
3rd	__________	__________	__________	Home Work Cell
	Address __________		__________	Home Work Cell

PART I – 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 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** ______________________

Address______________________

Other Medical Specialist ______________________ **Phone Number** ______________________

Address______________________

Dentist ______________________ **Phone Number** ______________________

Address______________________

Preferred Local Hospital______________________ **ER#** ______________________

Signature of Parent/Guardian______________________ **Date**______________

PART II – REFUSAL OF CONSENT FOR TREATMENT:

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 the following action:

____

____

____

Signature of Parent/Guardian______________________ **Date**______________

(Revised 5/09)