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 (Check One)** **Date of Birth** _____

Email Address(es) _____

Medical Conditions: _____

Allergies: _____

Current Medications: _____

If medication is required to be administered during school hours, please download & complete medication form(s) at: kentschools.net/forms

Child resides with (check 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:
1st		Parent/Guardian		☐ H ☐ Wk ☐ Cell
				☐ H ☐ Wk ☐ Cell
2nd				☐ H ☐ Wk ☐ Cell
				☐ H ☐ Wk ☐ Cell
3rd				☐ H ☐ Wk ☐ Cell
				☐ H ☐ Wk ☐ Cell
4th				☐ H ☐ Wk ☐ Cell
				☐ H ☐ Wk ☐ 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.

Phone Number:

Doctor _____ _____

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** _____

(Revised 5/16)