# EMERGENCY MEDICAL AUTHORIZATION

For the School Year of September _________ through August ________

Minor's Name ___________________________________ Male Female Date of Birth _____/_____/____

Address ________________________________________ Grade _____ School District _______________

City _____________________ State_________ Zip ___________Phone ____________________

Name of Legal Guardian: __________________________________________________________________

Name(s) of person with whom the student resides: ___________________________________________

Permission to contact non-custodial parent? Yes No NA

If yes, name and phone of that parent ___________________________ Phone ____________________

Known allergies: ___________________Health Concerns (asthma, diabetes, etc.) __________________

Any know food allergies: _________________________ Current medications: _____________________

Name of Insurance Company _________________________ Policy # ___________________________

An authorization of the provision of emergency treatment for students who become ill or injured while involved in a Grace Church function. PLEASE LIST ONLY THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOLVING THIS STUDENT. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e. 1st, 2nd).

# ____ Mother (Name) ____________________ Home # __________________Work #_____________

Employment ____________________ Cell # __________________ Pager #_____________

# ____ Father (Name) ____________________ Home # __________________Work #_____________

Employment ____________________ Cell # __________________ Pager #_____________

# ____ Other (Name) ____________________ Relationship to Student _________________________

Home #___________________ Work # _____________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by the preferred doctor indicated, or, in the event the designated, preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any reasonable accessible medical facility. This authorization does not cover major surgery unless the medical options of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

***PART 1 OR PART 2 MUST BE COMPLETED***

**PART 1**

I hereby consent for the following medical care providers to be called:

Preferred Physician ___________________________________ Phone __________________________

Preferred Dentist _____________________________________ Phone __________________________

Parent/Guardian Signature _____________________________ Date _____________________________

Preferred Hospital ________________________________________________________________________

**PART 2**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury I wish Grace Church at Willow Valley to take the following action: _______________________________

_____________________________________________________________________________________

Parent/Guardian Signature ____________________________ Date ____________________________