

**NORTH UNION LOCAL SCHOOL DISTRICT  
EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION**

**STUDENT INFORMATION** **PLEASE COMPLETE EACH LINE WITH BALLPOINT PEN**

Student's Name \_\_\_\_\_ Student ID # \_\_\_\_\_  
(Last) (First) Grade \_\_\_\_\_  
 Home address \_\_\_\_\_ Birth date \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Teacher \_\_\_\_\_  
 Home Telephone Number \_\_\_\_\_ Bus # / Driver \_\_\_\_\_  
 Student resides with:  Mother  Father  Stepmother  Stepfather  Other \_\_\_\_\_

**PARENT & EMERGENCY CONTACT INFORMATION**

<u>Biological Mother's Info</u>	<u>Biological Father's info</u>	<u>Step Parent / Guardian Info</u>
Name _____	Name _____	Name _____
Address _____	Address _____	Address _____
Home Phone _____	Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____	Cell Phone _____
Work Phone _____	Work Phone _____	Work Phone _____
Business Name _____	Business Name _____	Business Name _____
Email _____	Email _____	Email _____
Is the person listed above an emergency contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the person listed above an emergency contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the person listed above an emergency contact? <input type="checkbox"/> Yes <input type="checkbox"/> No

**List relatives or friends who will know your whereabouts and can assume temporary care of your child if you cannot be reached.**

**List contacts in the order you wish for us to call.**

1) Name \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_  
 2) Name \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_  
 3) Name \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_

\*If school is dismissed early due to any emergency, my child should go home or to the local address of: \_\_\_\_\_

**Purpose of the following information:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Fill out and sign ONLY Part 1 OR Part 2.**

**PART 1 - GRANTING CONSENT**

In the event reasonable attempts to contact me at (Tel. No.) \_\_\_\_\_ have been unsuccessful, I hereby give consent for:  
 (1) the administration of any treatment deemed necessary by (Physician) Dr. \_\_\_\_\_ at (Tel. No.) \_\_\_\_\_  
 or (Dentist) Dr. \_\_\_\_\_ at Tel. No. \_\_\_\_\_, 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 (preferred Hospital) \_\_\_\_\_ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

**PART 2 - 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 but to do the following: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_