Green Local Schools Emergency Medical Authorization & Residency Verification Form

Purpose of Emergency Medical Authorization: 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. **Part I or Part II on page 2 must be completed.**

Student Information

Student Name				School Building			
Grade		Homeroom		Gender		Birth Date	
Address				Home Phone*			
City/Zip				Mobile Phone*			

**of student, if applicable*

Primary Contact Name(s)

Person(s) responsible for the care of the student whom we should contact in an emergency situation

Name(s)		
Address, if different from student		
City/State/Zip		
Primary Phone *(check if mobile)*	☐ is mobile	☐ is mobile
Secondary Phone *(check if mobile)*	☐ is mobile	☐ is mobile
Work Phone *(check if mobile)*	☐ is mobile	☐ is mobile
E-mail Address		
Type of Contact *Check all that apply.* *See glossary for definitions.*	☐ Parent ☐ Legal Guardian ☐ Medical Contact *(may authorize care)* ☐ Available at Work ☐ Living with Student	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Medical Contact *(may authorize care)* ☐ Available at Work ☐ Living with Student

Secondary Contact Name(s)

Additional person(s) whom we may contact in an emergency situation.

Contact Name		
Address, if different from student		
City/State/Zip		
Primary Phone *(check if mobile)*	☐ is mobile	☐ is mobile
Secondary Phone *(check if mobile)*	☐ is mobile	☐ is mobile
Work Phone *(check if mobile)*	☐ is mobile	☐ is mobile
Type of Contact *Check all that apply.* *See glossary for definitions.*	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Medical Contact *(may authorize care)* ☐ Available at Work ☐ Emergency Contact ☐ Living with Student ☐ Copied on Correspondence ☐ Willing to Volunteer	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Medical Contact *(may authorize care)* ☐ Available at Work ☐ Emergency Contact ☐ Living with Student ☐ Copied on Correspondence ☐ Willing to Volunteer

Last, First ______________ Grade ______

Medical Contact Information

Primary Care Physician Name		Phone	
Dentist Name		Phone	
Medical Specialist Name		Phone	
Preferred Hospital		ER Phone	

Medical Conditions and Special Care

Medical Conditions	
Allergies	
Medications	
☐	Check here if special care or administration of medication may be required at school. Additional requests for information will be sent home by the district medical staff.

PART I—TO GRANT CONSENT

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 opinion of two (2) other licenses physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date____________________ Signature of Parent/Guardian ______________________________

PART II—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 the following action:

____

____

____

Date____________________ Signature of Parent/Guardian ______________________________

STUDENT MEDICAL INFORMATION FORM

(Please Print Clearly)

Student's Name (Last, First) ____

Residential Parent (Last, First) ____

Home Phone ____________________ Work/Other Phone ____________________________

Allergies

Does your child have any allergies to food or medicine? Yes ____ No____

If yes, please describe the reaction:

____

____

Medications

Medication your child is currently taking

Name of the medication	Dosage ordered/Number of pills

Consent To Administer Over-The-Counter Medication

May the nurse and/or the designee administer over-the-counter medications to your child for minor illness such as headache, upset stomach, muscle aches, sunburn, etc.? The medications provided will be in pill form. If your child requires liquid form, please add those medications to the list and send them to camp.

YES ________ **NO** ________

Parent/Guardian Signature ______________________________ Date ____________________

(Signature required in order to give medications)

Acknowledgement/Release

I have read, understand and completed this form as fully as possible and in doing so will not hold the Band nurse, Booster Organization, Band Directors or Green High School responsible and/or liable for any injuries or treatments given.

Parent/Guardian Signature ______________________________ Date ____________________