

Student Name: \_\_\_\_\_

Check if any information has  
changed from previous year.

Last

First

Middle

Year: \_\_\_\_\_

**Beachwood City School District**

Grade: \_\_\_\_\_

School: \_\_\_\_\_

**Emergency Medical and Legal Authorization**

Teacher: \_\_\_\_\_

**(Please Print)**

Purpose: 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.

Residential Parent(s)/Guardian(s) \_\_\_\_\_

name and relationship

name and relationship

Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Student Birthdate: \_\_\_\_\_

**Check ONLY**  Parent/Guardian

Home Phone ( ) \_\_\_\_\_ if Email address has \_\_\_\_\_ Email Address: \_\_\_\_\_

Area Code

changed from previous year

Mother Daytime Phone ( ) \_\_\_\_\_ Cellular / Pager Number ( ) \_\_\_\_\_

Area Code

Area Code

Father Daytime Phone ( ) \_\_\_\_\_ Cellular / Pager Number ( ) \_\_\_\_\_

Area Code

Area Code

Non-custodial parent \_\_\_\_\_ ( ) \_\_\_\_\_

Name

Address

Area Code/Phone

Restraining Order: Yes No

In an emergency, the following have permission to be contacted and my child released to:

Name

Relationship

Area Code/Phone

1 \_\_\_\_\_ ( ) \_\_\_\_\_

2 \_\_\_\_\_ ( ) \_\_\_\_\_

Transportation: Bus route # to school \_\_\_\_\_ Bus route # from school \_\_\_\_\_

Walk \_\_\_\_\_

**REVERSE SIDE MUST BE FILLED OUT**

Rev. 5/07

**Attention: Give accurate, up-to-date facts concerning the child's medical history, health status allergies and medications.**

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

Is there any critical medical information the bus driver should be aware of when transporting this student? \_\_\_\_\_

**Check One - Part 1 or Part II AND sign below:**

In the event reasonable attempt to contact me or the other persons listed on this card have been unsuccessful:

**Part I To GRANT Consent**

**I grant consent**

I hereby give my consent for (1) the administration of any treatment deemed necessary by

Doctor \_\_\_\_\_

(Preferred Physician)

Area Code/Phone Number \_\_\_\_\_

Doctor \_\_\_\_\_

(Preferred Dentist)

Area Code/Phone Number \_\_\_\_\_

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 \_\_\_\_\_ or 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, and obtained prior to the performance of surgery.

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

\_\_\_\_\_ Date

\_\_\_\_\_ Street Address

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip Code

**Part II REFUSAL to Grant Consent**

**I refuse to grant consent**

I do not grant 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 or Guardian: \_\_\_\_\_

\_\_\_\_\_ Date

\_\_\_\_\_ Street Address

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip Code