

STOW MUNROE FALLS HIGH SCHOOL EMERGENCY MEDICAL CARD

(We MUST have full legal name)

NAME _____
(Last) (First) (Middle) (Homeroom) (Grade)
ADDRESS _____
Birth date _____
CITY _____ Zip _____ Place of birth (city) _____ (st) _____
Home Phone # _____

FATHER'S NAME _____ Home Phone # _____
same address ___ yes ___ no Work Phone # _____
FATHER'S PLACE OF EMPLOYMENT _____ Cell/Pager-Father _____

MOTHER'S NAME _____ Home Phone # _____
same address ___ yes ___ no Work Phone # _____
MOTHER'S PLACE OF EMPLOYMENT _____ Cell/Pager-Mother _____

GUARDIAN _____
(if different than parent) _____ Home _____ Work _____

1 ALTERNATE CONTACT _____
(Name) (Relationship) (Phone)

2 ALTERNATE CONTACT _____
(Name) (Relationship) (Phone)

Parents Email Address _____

MEDICAL ALERT: _____

MEDICATIONS: _____

EMERGENCY MEDICAL AUTHORIZATION

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. PART I or PART II must be completed.

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number), or _____, other parent or guardian at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____, physician, or, dentist, 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 _____ (hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, 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

Address _____

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 no action or to

Date _____
Signature of Parent or Guardian

Address _____