EMERGENCY MEDICAL AUTHORIZATION
Liberty Center Schools

(Please use black pen when filling out form)

Student Name:		Grade:	Bus #:
Street Address:		Home Phone: ( )	
P.O. Box:		Date of Birth:	
City	Zip:	Parent Email:	

Please fill out the following information to enable parent or guardian to give authorization for the provision of emergency treatment or to pick-up the child should he/she become ill or injured while under school authority, when parents or guardians cannot be reached.
Residential Parent or Guardian ****Please list both first and last names.****

Custody: Are there court custody papers regarding this student? _____Yes _____No (If yes, √ who has custody.)

	Mother's Name:	Daytime Phone: ( )
	Mother's Cell Phone:	Daytime Workplace Name (or home):
	Father's Name:	Daytime Phone: ( )
	Father's Cell Phone:	Daytime Workplace Name (or home):
	Other's Name:	Daytime Phone: ( )
	Other's Cell Phone:	Daytime Workplace Name (or home):
	Childcare Provider:	Relationship:
	Address:	Daytime Phone: ( )
	Address:	Cell Phone: ( )

Part I or II Must Be Completed

Part I: TO GRANT CONSENT - I hereby give consent for the following medical care providers and local hospital to be called:

Physician:	Phone: ( )
Dentist:	Phone: ( )
Medical Specialist:	Phone: ( )
Local Hospital:	Phone: ( )

In the event 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 doctors, 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 reasonable accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physician 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 impairment to which a physician should be alerted:

_____

_____

Signature of Parent/Guardian _____ Date _____

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:

_____

_____

Signature of Parent/Guardian _____ Date _____