GRAND VALLEY LOCAL SCHOOL DISTRICT

STUDENT EMERGENCY MEDICAL AUTHORIZATION FORM

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.

Student's Name (**Last, First, MI**) _____ Grade_____

Street Address_____P.O. Box _____

Parent/Guardian

City/State/Zip_____**Phone #**_____

***Please check if this is a new address*:** ☐ Date of Birth_____ Bus #_____

Military Status (If applicable): ☐ Mother ☐ Father ☐ Active ☐ Inactive ☐ Guard ☐ Reserve ☐ N/A	**Military Branch:** ☐ Army ☐ Air Force ☐ Marines ☐ Navy ☐ Coast Guard
Military Status (If applicable): ☐ Mother ☐ Father ☐ Active ☐ Inactive ☐ Guard ☐ Reserve ☐ N/A	**Military Branch:** ☐ Army ☐ Air Force ☐ Marines ☐ Navy ☐ Coast Guard

CUSTODIAL PARENT(S) (circle all that apply): Mother Father Guardian Grandparent Other_____

***If custody has changed, please furnish the school office with a copy of the court order designating custodial/residential parent*.**

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd). Please write legibly.

___ Mother: _____Cell/Primary#: _____Work #: _____

Email Address:_____

___ Father: _____Cell/Primary#: _____Work #: _____

Email Address:_____

___ Stepparent: _____Cell/Primary#: _____Work #: _____

Email Address:_____

___ Guardian: _____Cell/Primary#: _____Work #: _____

Email Address:_____

___ Relative or alternate (Emergency Contact), if applicable: Relationship to Child:_____

Name: _____Cell/Primary#: _____Work #: _____

Email Address:_____

BROTHERS/SISTERS IN GRAND VALLEY LOCAL SCHOOLS:

NAME	GRADE	NAME	GRADE

EMERGENCY MEDICAL AUTHORIZATION FORM MUST BE COMPLETED ON REVERSE SIDE

Continued - Student's Name _____ **Grade** _____

PERTINENT MEDICAL INFORMATION:

Please provide pertinent medical information, including allergies, medications, and disabilities.

Allergies (medication, environmental, insects)_____

Medication(s)_____

Medical & Physical Conditions_____

_____

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: _____

GRANT TO CONSENT: PREFERRED HEALTH PROVIDERS:

I hereby give consent for the following medical care providers and local hospital to be called:

DOCTOR	**DENTIST**	**LOCAL HOSPITAL**
Phone:	**Phone:**	**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 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 opinions of two (2) other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

*****PLEASE NOTE: GRAND VALLEY ELEMENTARY SCHOOL and GRAND VALLEY MIDDLE SCHOOL Do NOT provide non-prescription medications (Ibuprofen and Acetaminophen).*****

FOR GRAND VALLEY MIDDLE SCHOOL ONLY: If you would like your child to have non-prescription medications, please provide Ibuprofen and/or Acetaminophen labeled with your child's name and a written note authorizing Grand Valley Local Schools' designated staff to administer as necessary, (according to package dosage schedule) consistent with age and weight guidelines.

FOR GRAND VALLEY HIGH SCHOOL ONLY: I hereby authorize Grand Valley Local Schools' designated staff to administer the following non-prescription medication(s) as necessary, (according to package dosage schedule) consistent with age and weight guidelines to my child:

Ibuprofen (Advil, Motrin): Yes☐ No☐ / Acetaminophen (Tylenol, Non-aspirin Pain Reliever): Yes☐ No☐

I release and agree to hold Grand Valley Local Schools, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ Date _____