Grade Level _____ **EMERGENCY MEDICAL AUTHORIZATION** ***Raider Care*** **BL-510**
BENJAMIN LOGAN LOCAL SCHOOL DISTRICT **01/24/14**

NOTE: **FORM MUST BE COMPLETED IN INK**

In accordance with HB 639, the following emergency information authorization has been received from the State Department. We must have one of these completed for each student and kept in their permanent record file. (This will be completed annually.)

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 Name _____ Address _____

Home Telephone Number _____ PO Box _____
(This is the phone number that will be used for ALL notifications-must be parent or guardian)

Building Attended _____ _____

County in which you reside _____

Residential Parent or Guardian:
Mother _____ Home Phone _____ Work Phone _____
Address _____ Cell Phone _____ Where is this? _____
City _____ Email address: _____

Father _____ Home Phone _____ Work Phone _____
Address _____ Cell Phone _____ Where is this? _____
City _____ Email address: _____

Relative or childcare provider: _____ Relationship _____ Phone _____

Address _____

Other Name _____ Relationship _____ 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:

Doctor _____ 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 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 other licensed physicians or dentists, concurring in the necessity of 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: _____

_____

_____

_____ _____
Date Signature of Parent or Guardian

_____
Address

OVER

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 or Guardian

_____

Address

BENJAMIN LOGAN LOCAL SCHOOL DISTRICT
RELEASE AUTHORIZATION

It is the policy of the Benjamin Logan School District to release students only to people that have been authorized by parents/guardians. Sometimes a student becomes ill, is injured, needs to be picked up in case of an emergency, etc., and the school is unable to reach a parent/guardian.

Please complete the following information and list the names, addresses and telephone numbers of persons you authorize the school to contact in case of an emergency if you cannot be reached. **If you need to have someone other than a person listed below pick up your child (for a dental/medical appointment, a family emergency, etc.), please make sure you notify the school who will be picking the child up.**

In addition to those people listed on the front of the form, I hereby authorize the following person(s) to be contacted in case of an emergency and give them permission to pick up my child if I cannot be reached:

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Student's Name:_____ Grade:_____

Parent/Guardian Signature_____ Date:_____