

Emergency Medical Authorization 2026-2027



This form **MUST** be completed by the first day of school each year. A separate form must be completed for each child. Please print legibly.

Student Name _____ Grade _____ Birthdate _____

Primary Phone _____ Address _____ City, Zip _____

Student's Ethnicity (OPTIONAL choose one): Hispanic/Latino Not Hispanic/Latino

Student's Race (OPTIONAL choose one or more regardless of ethnicity): Asian American Indian or Alaska Native Black or African American White Native Hawaiian or other Pacific Islander Multiracial

Emergency Contacts: LIST AT LEAST 3 EMERGENCY CONTACTS! (Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority. In addition these contacts will have the authority to pick up your student from school.)

Parent/Legal Guardian Name	Email	Phone #1	Cell	Work	Other	Phone #2	Cell	Work	Other
Parent/Legal Guardian Name	Email	Phone #1	Cell	Work	Other	Phone #2	Cell	Work	Other
Name	Relationship	Phone #1	Cell	Work	Other	Phone #2	Cell	Work	Other
Name	Relationship	Phone #1	Cell	Work	Other	Phone #2	Cell	Work	Other

COMPLETE PART I OR PART II – NOT BOTH!

Part I: To Grant Consent

I hereby give my consent for the administration of any treatment deemed necessary by the preferred physician, dentist, specialist and/or hospital listed below: OR in the event the designated preferred practitioner or hospital is not available, by another licensed physician or dentist 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 are obtained prior to the performance of such surgery.

Physician _____ Phone _____

Medical Specialist _____ Phone _____

Dentist _____ Phone _____

Preferred Hospital _____ Phone _____

Signature of Parent / Legal Guardian _____

Date _____

Part II: Refusal to Consent (DO NOT complete if Part I is completed)

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 / Legal Guardian _____

Date _____

GRADES 5-8 ONLY

Acetaminophen, 500 mg tablet. Please, give my child () 1 tablet or () 2 tablets if requested. **Tablets only, no liquid or chewable provided.**