2022-23 Emergency Medical Authorization

This form can be used for all BPA Field Trips during the 2022-23 school year

Student Name ______________________ Date of Birth ______________________

Student ID # ______________________ Grade __________ Homeroom __________ Home Telephone Number ______________________

Student Address ______________________ City __________ State __________ Zip code ______________________

Student lives with ___ Mother ___ Father ___ Both ___ Guardian ___ Foster (Check one)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot he reached.

Residential Parent/Guardian Information

Parent/Guardian Name______________________ Daytime Phone __________ Alternate # __________

Other Parent Name ______________________ Daytime Phone __________ Alternate # __________

Address (if different than student) ______________________

Other Emergency Contacts______________________ Daytime Phone __________ Alternate # __________

Relationship to student ______________________ Daytime Phone __________ Alternate # __________

Name of Childcare Provider

Name______________________ Relationship ______________________

Address ______________________ Phone ______________________

EMERGENCY MEDICAL AUTHORIZATION

************ PART I OR PART II MUST BE COMPLETED AND SIGNED************

PART I MUST BE COMPLETED TO GRANT CONSENT: I hereby give consent for the following medical care providers/local hospital to be called

Doctor's Name ______________________ Phone Number ______________________

Dentist's Name ______________________ Phone Number ______________________

Local Hospital ______________________Phone Number ______________________

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 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.

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Date______________________ Signature of Parent/Guardian ______________________

Address ______________________

PART II - REFUSAL TO CONSENT DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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.

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Date ______________________ Signature of Parent/Guardian ______________________

Address ______________________