Springer
School and Center

This form effective school year:
**2016-2017**
****This form has 2 sides****

______________________
STUDENT'S LAST NAME

# EMERGENCY MEDICAL AUTHORIZATION and CONTACT CARD

Student Name:______________________ Date of Birth:__________ Home Phone:__________

Street Address:____________________Apt #______ City:__________ State:______ Zip:______

Student Lives with:______________ Preferred Contact for School Communications (name): ______________

Preferred Email Address: ________________________________

| **Parent/Legal Guardian Information:** | **Home phone:** | **Work Phone:** | **Cell Phone:** |
|---|---|---|---|
| **Mother's Name:** First Last | | | |
| **Father's Name:** First Last | | | |
| **Other's Name:** First Last Relationship to Child | | | |

***Purpose: If a child becomes ill or is injured at Springer, we will make reasonable effort to contact the parents/guardians.***
**Persons OTHER THAN Parents/Guardians to contact if Parents/Guardians CANNOT be reached:**

Name: ______________________
Relationship to child: ______________
Phone: ______________________
Address: ______________________

Name: ______________________
Relationship to child: ______________
Phone: ______________________
Address: ______________________

**FOR OFFICE USE ONLY – DISTRIBUTION:**
☐ School Office ☐ Business Office
☐ Main Office ☐ Assistant Principal
☐ Homeroom:

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

**I. TO GRANT CONSENT:**
In the event that injury or serious illness occurs when I cannot be contacted, I hereby authorize the school to call the medical personnel listed for instructions or to make whatever arrangements are necessary:

**PREFERRED PHYSICIAN:** ______________________ **PHONE:** __________
**PREFERRED DENTIST:** ______________________ **PHONE:** __________
**PREFERRED HOSPITAL:** ______________________ **PHONE:** __________

______________________________ __________
**SIGNATURE OF PARENT/GUARDIAN** **DATE**

**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 no action or to:______________________

______________________________________________

______________________________ __________
**SIGNATURE OF PARENT/GUARDIAN** **DATE**

**CHRONIC ILLNESS/ALLERGY ALERT - Indicate if your student has the following.**
**Chronic Illness? ☐ Yes ☐ No Severe Allergy? ☐ Yes ☐ No Asthmatic? ☐ Yes ☐ No**
***IF YES - Complete separate form with details and care plan.***