STUDENT NAME____
(*Please print*) Last First (ID #)

Broad Ripple Magnet High School
EMERGENCY MEDICAL AUTHORIZATION FORM

Date of Birth_____________________________________ Home Phone__________________________

School____ Address_________________________________

School Year___________________ Grade_______________ City ___________________________ Zip__________

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel, including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name______________________________ Daytime Phone___________________ Cell___________________

Father's Name______________________________ Daytime Phone___________________ Cell___________________

Emergency Contacts:
1. ______________________________ Daytime Phone___________________ Cell_________________
2. ______________________________ Daytime Phone___________________ Cell_________________
3. ______________________________ Daytime Phone___________________ Cell_________________

Please identify any health concerns that school personnel should be aware of:

Allergies No _____ Yes _____ Specify ___________________________

Epi Pen No _____ Yes _____ ***If yes, Epi Pen Authorization Form must be complete.***

Asthma No _____ Yes _____ ***If yes, Inhaler Authorization Form must be completed.***

Seizures No _____ Yes _____ Emergency seizure medications? ____
Name of medication

Diabetes No ______ Yes _____ Emergency diabetic medications? ____
Name of medication

Does your student take any medication regularly? No ____ Yes ____ Specify ____
Name of medication, amount taken, how often

Will your student take medication at school? No ____ Yes ____ ***If yes, Permission to Dispense Medication Form must be completed***.

Are there any other medical conditions that school personnel should be aware of? ____

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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/Emergency Room 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 doctors, or, in the event the designated 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.

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Signature of Parent/Guardian Date

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:

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Signature of Parent/Guardian Date

Revised 11/16