

Niles City School District
EMERGENCY MEDICAL AUTHORIZATION

Niles McKinley HS Niles Middle School

Homeroom Number _____ Homeroom Teacher _____ Grade _____

STUDENT INFORMATION

Name _____

First

Middle

Last

Birth Date ____/____/____ Gender Male Female

Address _____

Street

City

State

Zip

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name _____ Email _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Father/Guardian Name _____ Email _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Married Divorced Separated Never Married Guardian/Custodian is not Parent
If unmarried, Residential Parent for School Purposes is Mother is Father is Both Parents

EMERGENCY CONTACTS (Include Parents/Guardians and all other Contacts)

Niles City School's Staff will contact the persons listed below in order. If unavailable, the next person will be called. The student will only be released to persons listed below.

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Name _____ Relationship to Child _____

Phone #1 (____)____-____ Phone #2 (____)____-____ Phone #3 (____)____-____

Student's Name _____ Grade _____

STUDENT'S SIBLING INFORMATION

List first name, last name, and grade of student's school aged siblings

First/Last Name _____ Grade _____
First/Last Name _____ Grade _____
First/Last Name _____ Grade _____
First/Last Name _____ Grade _____
First/Last Name _____ Grade _____
First/Last Name _____ Grade _____

MEDICAL CONSENT

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 the below-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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Physician _____ Phone (____)____ - _____
Dentist _____ Phone (____)____ - _____
Medical Specialist _____ Phone (____)____ - _____
Preferred Hospital _____ Phone (____)____ - _____

Please list the facts concerning the child's medical history, including allergies, medications, and any physical impairments to which a physician should be alerted.

Parent/Guardian Signature _____ Date ____ / ____ / ____

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 actions:

Parent/Guardian Signature _____ Date ____ / ____ / ____