GRADE _____ **Aurora School District** **E-MAIL_____**

EMERGENCY MEDICAL AUTHORIZATION

Student Name _____Address _____

Home Phone_____ Custodial Parent(s) [ ] Mother [ ] Father [ ] Both

Name _____ [ ] Mother [ ] Stepmother [ ] Other_____

Place of Employment_____ Work Phone _____Cell Phone_____

Name _____ [ ] Father [ ] Stepfather [ ] Other_____

Place of Employment_____ Work Phone _____Cell Phone_____

Other relative or neighbor to be called and student released to if the above person cannot be contacted:
Name_____Phone _____Relationship_____ or **Name_____**

Phone_____Relationship_____ If applicable, restrictions regarding student's release during the day_____ ***Is there a court order which limits/prohibits non-custodial parent contact? YES NO If yes is circled, parent must contact the office, and provide legal documentation.***

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 _____

I hereby authorize Aurora city Schools' personnel to administer basic first aid to my child in the event of minor injury at school or during school sponsored activities or field trips. Parents will be contacted if more extensive treatment is required.

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:

_____
_____
_____

Date _____ **Signature of Parent/Guardian _____**

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:

_____

Date _____ **Signature of Parent/Guardian _____**