School Year 2021/2022
Please Print

Jackson City Schools

Student Emergency Information - Emergency Medical Authorization Form

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.

_____ _____ (_____)_____
Legal Last Name First Middle Sex Home Phone

_____ _____ _____
Address City Zip Code

_____ _____ _____
Mailing Address (P.O. Box) Grade Date of Birth

EMERGENCY CONTACTS

****STUDENT RESIDES WITH (Please Circle) -Mother -Father -Both Parents -Legal Guardian**

****If divorced or separated, parent with Legal Custody:** _____
(Most Recent Court Paperwork Must Be On File)

Mother/Legal Guardian	**Father/Legal Guardian**
Last Name First Name	**Last Name First Name**
Address	**Address**
(_____) _____ **Home Phone**	(_____) _____ **Home Phone**
(_____) _____ **Cell Phone**	(_____) _____ **Cell Phone**
(_____) _____ **Work Phone**	(_____) _____ **Work Phone**
Employer: _____	**Employer:** _____

Email Address (optional): _____

PLEASE LIST ADDITIONAL EMERGENCY CONTACTS WHO CAN PICK UP STUDENT

_____ (___) _____ _____
Name Phone Relationship

_____ (___) _____ _____
Name Phone Relationship

_____ (___) _____ _____
Name Phone Relationship

Name of Siblings Attending Jackson City Schools	**School Building**	**Grade**

MUST COMPLETE REVERSE SIDE

Districts are required to identify students whose parents or legal guardians have been an active member of the Armed Forces or National Guard at any time throughout the current year. **Please check ✔ the option below that best describes the student's Military Student identifier status at any point during the school year.**

- _____ * - **Not Applicable** (Not a Military Student)
- _____ **A** - **Active Duty**- Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marines Corp or Coast Guard)
- _____ **B** - **National Guard**- Student is a dependent of a member of the National Guard (Army or Air)

Medical Insurance: _____ **ID#** _____

Provider: _____

PART I: TO GRANT CONSENT

Physician: _____ **Phone: (_____)** _____

Dentist: _____ **Phone: (_____)** _____

Medical Specialist: _____ **Phone: (_____)** _____

Local Hospital: _____ **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 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 physical impairments to which a physician should be alerted:

_____

_____

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

Address _____

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:

_____

_____

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

Address _____

PART I OR II MUST BE COMPLETED