EMERGENCY MEDICAL & STUDENT RELEASE AUTHORIZATION

Student Last Name ______________________ Student First Name ______________________

EMERGENCY CONTACTS: In case of an emergency with your student, the school office will call and notify you at the primary phone number provided. If you are not reached at the primary number, phone calls will be made to the contacts and phone numbers listed below in the order given until someone is notified. The same procedure will be used each day after 9 a.m. if your elementary student is absent and the school has not been notified. Automated attendance calls are used at the middle schools and LHS.

Child's Name __________________________________ **Grade** ______ **Primary Contact:** _______________________________

Address: ____ **Primary Contact Phone:** _______________________________

Secondary Contacts Print Full Name	Home Phone	Work Phone	Cell Phone	Can authorize medical treatment? (X for yes)	Can release student to this person? (X for yes)
1st Contact Other Than Above/ Relationship	( )	( )	( )		
2nd Contact/Relationship	( )	( )	( )		
3rd Contact/Relationship	( )	( )	( )		
4th Contact/Relationship	( )	( )	( )		

PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for:
(1) the administration of any treatment deemed necessary by:

(Physician) Dr. _____________________________ Address _______________________________Phone (___)_______________,

(Dentist) Dr. _____________________________ Address _______________________________Phone (___)_______________,

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 preferred hospital: ☐ Lakewood ☐ Fairview
If your child needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, food supplements, modified diets, fluoride supplements, and any physical impairment to which a physician should be alerted:___________________________

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Date:___________________________________ Parent Signature:____

LAKEWOOD
CITY SCHOOLS

If You Completed Part 1 On Page 1 – Do NOT Complete Part 2 in Box Below

PART 2 – REFUSAL TO CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, 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:

Date:_________________________________ Parent Signature:_______________________________________