

Fairbanks Local School District Emergency Information/Medical Authorization/Temporary Care

STUDENT _____ DOB _____ Teacher/Grade _____ / _____

Home Address _____ Home Phone _____
Street PO Box# City Zip Code

Mother/legal guardian _____ Father/legal guardian _____

Home address if different from above _____ Home address if different from above _____

Place of employment/city location _____ Place of employment/city location _____

Work phone _____ Cell phone _____ Work phone _____ Cell phone _____

E-mail address _____ E-mail address _____

People listed below are ones who will know your whereabouts and are able to transport your child from school and assume temporary custody of them if needed. Please note if there is someone you want contacted first. Check here if more names are on the backside ___=>

_____	Relationship _____	phone numbers(s) _____	_____
_____	Relationship _____	phone numbers(s) _____	_____
_____	Relationship _____	phone numbers(s) _____	_____

MEDICAL HISTORY _____ **Check here if no known medical conditions** _____

Allergies _____

Medications being taken _____

Physical Impairments _____

Health Concerns _____

Check here if more information is on the backside ___=>

PURPOSE OF THE FOLLOWING INFORMATION: 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.

PART I - GRANT TO CONSENT

In the event reasonable attempts to contact me at (phone #) _____ have been unsuccessful, I hereby give my consent for: (1) The administration of any medical treatment deemed necessary by (Physician) Dr. _____ at (phone #) _____ or (Dentist) Dr. _____ at (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) _____ or 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.

PARENT/GUARDIAN SIGNATURE _____ **Date** _____

OR

PART II - REFUSAL TO CONSENT (Do Not Complete Part II if you completed Part I)

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action but to do the following _____

PARENT/GUARDIAN SIGNATURE _____ **Date** _____