

FIELD TRIP AND EMERGENCY MEDICAL AUTHORIZATION
CRESTWOOD LOCAL SCHOOLS

10/29/2009

School Year: _____	Student Name: _____
School: _____	Address: _____
Grade: _____	_____
Teacher: _____	Mailing Address: _____ Zip: _____
D.O.B: _____	Phone Number: _____
SSN: _____	Cell Phone #: _____

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority.

PART I OR PART II MUST BE COMPLETED

PART I – CUSTODIAL PARENT TO GRANT CONSENT

Mother's Name: _____	Daytime Phone: _____
	Cell Phone: _____
	Email Address: _____
Father's Name: _____	Daytime Phone: _____
	Cell Phone: _____
	Email Address: _____

Local alternate persons to be notified in case neither parent can be reached. (Please list the name of a neighbor, babysitter, friend, or relative who will come to the school to pick up your child and assume the responsibility of his/her care during absence from the home):

Name: _____	Daytime Phone: _____
Relationship: _____	Cell Phone: _____
Name: _____	Daytime Phone: _____
Relationship: _____	Cell Phone: _____
Doctor's Name: _____	Phone No: _____
Dentist's Name: _____	Phone No: _____
Specialist to be called: _____	Phone No: _____
Preferred Hospital: _____	Phone No: _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-mentioned doctor or, in the event, the designated practitioner isn't available, by any other licensed physician or dentist: and (2) the transfer of the child to the 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 concur in the necessity for such surgery, and 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 are:

***Signature of Parent/Guardian (to grant consent):** _____ **Date:** _____

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 no action or to: _____

Signature/Parent or Guardian (to refuse consent): _____ **Date:** _____