# Dayton Christian School System
# Emergency Medical Authorization Form

**NAME OF CHILD** _____Birthdate_____

Homeroom/Devotional Teacher _____Grade _____ School Year 20____20____

Home Address _____ School District _____

City_____Zip_____Home Phone _____ Student's Cell_____

Student lives with_____

**PARENT'S OR LEGAL GUARDIAN'S NAMES AND PHONE NUMBERS**

Name _____Relationship_____ Cell:_____ Work/Home _____Email_____

Name _____Relationship_____ Cell:_____ Work/Home _____Email_____

Are there any custody issues with this student? ___Yes ___ No If yes, please explain_____

Names and grades of siblings_____

Permission for older siblings to transport younger siblings ___Yes ___No

**AUTHORIZED PERSONS** to assume responsibility for school dismissal and provision of care when parent or guardian listed above cannot be reached. Students will only be released to parent or guardian or those authorized by parent or guardian.

1._____ Relationship_____ _Cell: _____Work/Home_____

2._____ Relationship_____ _Cell: _____Work/Home_____

3._____ Relationship_____ _Cell: _____Work/Home_____

4._____ Relationship_____ _Cell: _____Work/Home_____

**MEDICAL INFORMATION** The following medical information may be shared with your student's teachers, secretary, counselor, principal, physical education teacher, cafeteria staff, athletic director, coach and all clinic staff unless otherwise instructed.

____Asthma ____ Seizures ____ Diabetes ____Severe Allergy to _____ Epipen ____Yes____No

Other_____

Physical impairments_____

Medications currently taking _____

Do any of the above medical conditions require medication at school? ___Yes___No

*(See clinic staff if child has allergies, diabetes, asthma, seizures, health concerns or medications to complete appropriate medical forms.)*

Family Physician or Pediatrician_____Phone_____

Family Dentist_____Phone _____

Local Hospital Preference _____

Insurance which applies to child_____

___ **CONSENT FOR EMERGENCY TRANSPORTATION AND MEDICAL TREATMENT:** In the event my/our child needs to be transported by ambulance or emergency vehicle, I/we authorize transportation. In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give my/our consent for administration of any treatment deemed necessary by Dr. _____(preferred doctor) or Dr_____ (preferred dentist); or, in the event the designated practitioner is not available, by another doctor or dentist; and the transfer of the child to the above stated hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

___ **REFUSAL OF CONSENT**. I/We do not give my/our consent for emergency medical treatment or emergency transportation of my/our child. In the event of illness or injury requiring emergency treatment, I/we wish the school authorities to take no action or to:_____

**SIGNATURE(S) OF PARENTS/GUARDIANS**_____ Date: _____

_____Date:_____