

# 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)	
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**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 \_\_\_\_\_