## Community School Corporation of Eastern Hancock County Emergency Medical Authorization

The Community School Corporation of Eastern Hancock County is seeking your permission to have your son or daughter treated at a doctor's office or hospital in the event that he or she is found in need of emergency medical treatment. If an emergency occurs, every effort will be made to contact you. However, if such contact cannot be made, this Emergency Medical Authorization may facilitate prompt treatment.

The Corporation will follow the instruction of this Emergency Medical Authorization Form to the extent possible in the event of a medical emergency. However, Eastern Hancock will defer to instructions and protocols of licensed health care professionals and/or first responders on the scene.

Student Name			
Address			
Birth date	Age	Grade	Home Phone
Father/Guardian Name			Cell Phone
Mother/Guardian Name			Cell Phone
Father's Employer	•		Business Phone
Mother's Employe	er		Business Phone
Family Doctor			Phone
Family Dentist			Phone
Preferred Hospita	1		Insurance Company
ID Number			Group Number
Health Alert (allergies, medication allergies, diabetes, asthma, etc.)			

## Medicine(s) Presently Taking

If parents cannot be contacted, list two emergency contacts.

2. Name \_\_\_\_\_ Phone \_\_\_\_\_

<u>Grant Consent</u>

**I give my consent** for emergency medical or dental treatment for my child who may become injured or ill while under school authority. I understand this authorization does not cover any 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.

Signature of Parent/Guardian\_\_\_\_\_

Date: