

BUSINESS PROFESSIONALS OF AMERICA

2019-20 Emergency Medical Authorization

This form can be used for all BPA Field Trips during the 2019-20 school year

Student Name _____ Date of Birth _____
Student ID # _____ Grade _____ Homeroom _____ Home Telephone Number _____
Student Address _____ City _____ State _____ Zip code _____
Student lives with Mother Father Both Guardian Foster (Check one)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached.

Residential Parent/Guardian Information

Parent/Guardian Name _____ Daytime Phone _____ Alternate # _____
Other Parent Name _____ Daytime Phone _____ Alternate # _____
Address (if different than student) _____
Other Emergency Contacts _____ Daytime Phone _____ Alternate # _____
Relationship to student _____ Daytime Phone _____ Alternate # _____

Name of Childcare Provider

Name _____ Relationship _____
Address _____ Phone _____

EMERGENCY MEDICAL AUTHORIZATION

***** PART I OR PART II MUST BE COMPLETED AND SIGNED*****

PART I MUST BE COMPLETED TO GRANT CONSENT: I hereby give consent for the following medical care providers/local hospital to be called

Doctor's Name _____ Phone Number _____
Dentist's Name _____ Phone Number _____
Local Hospital _____ Phone Number _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

Date _____ Signature of Parent/Guardian _____
Address _____

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 of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action.

Date _____ Signature of Parent/Guardian _____
Address _____