**Financial Services**

A Butler Tech Business Program

# 2024/25 Emergency Medical Authorization

**This form can be used for all BPA Field Trips during the 2024/25 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 he 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 _____