

School \_\_\_\_\_

Date \_\_\_\_\_

**2008- 2009 School Year  
Vandalia-Butler City School District  
Emergency Medical Authorization Form O.P.C.3313.712**

The purpose of this form is to enable parents/guardians to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when parents or guardians cannot be reached.

Student Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Signature: Parent/Guardian \_\_\_\_\_

**EMERGENCY INFORMATION**

List in order how contacts are to be made in the event of an emergency, discipline, attendance, etc. Parents, please don't forget to include yourself in the list of emergency contacts. (Include work phone)

**CONTACT 1**

**CONTACT 2**

**CONTACT 3**

Name \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Day/Work Phone \_\_\_\_\_

Day/Work Phone \_\_\_\_\_

Day/Work Phone \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**Part I to Grant Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_

Phone \_\_\_\_\_

Dentist \_\_\_\_\_

Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_

Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_

Insurance \_\_\_\_\_

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 by another licensed physician or dentist (providing the designated physician or dentist is not available); 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 dentist, 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.

This information may be shared with school personnel if it is pertinent to my child's health and safety, educational progress, and/or behavioral management plan.

Signature: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**Part II to Not Grant Consent**

I DO NOT GIVE CONSENT for emergency medical treatment for my child. In the event of illness or in the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**Vandalia-Butler City School District  
PERMISSION FOR FIELD TRIPS**

The purpose of this form is to secure permission from parents so that their child/children may participate in Board of Education sponsored field trips. This permission will be for a school year. The classroom teacher will be responsible for notifying the parents prior to all field trips.

Permission is granted for \_\_\_\_\_ to go on field trips under the supervision of a Vandalia-Butler School professional staff member.

Parents will be notified prior to all field trips during the applicable school year.

Signature: Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_