**C525-E Franklin Township Community School Corporation Emergency Medical Authorization**

Franklin Township Community School Corporation (FTCSC) 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.

FTCSC will follow the instruction of this Emergency Medical Authorization Form to the extent possible in the event of a medical emergency. However, FTCSC 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 Employer Business Phone

Family Doctor Phone

Family Dentist Phone

Preferred Hospital Insurance Company

ID Number Group Number

Health Alert (allergies, medication allergies, diabetic, asthma, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicine(s) Presently Taking

If parents cannot be contacted, list two emergency contacts.

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Grant Consent

**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 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.

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