



**Student information in case of emergency**

Student name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Allergies or chronic illnesses \_\_\_\_\_

Daily medications \_\_\_\_\_

**Contact information in case of emergency**

Parent/guardian name \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Parent/guardian name \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Emergency contact name \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

If above named cannot be contacted, we, the undersigned parent/guardian of the student identified above, hereby authorize officials of the above school district to contact directly the following physician and we hereby certify that we are the parents/guardian of the said minor child, and do authorize the physician named below to render such treatment as said physician in an emergency, for the health of said child, without further authorization than here expressed. In the event that the physician here named can't be contacted, or either of us is unavailable to give our express consent at such time with reference to any other physician, we hereby consent and authorize the officials of the school district to contact any licensed physician, and we hereby authorize said physician to render such treatment as he/she may deem reasonably necessary, in what he/she may consider to be an emergency, for the health of the aforesaid minor child.

I also understand that expenses incurred as a result of emergency ambulance use, treatment by physician, or treatment in a hospital or clinic will not be borne by the school or school personnel.

Physician \_\_\_\_\_ Hospital \_\_\_\_\_ Dentist \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Insurance company name \_\_\_\_\_

NOTE: When a student becomes ill or is injured on an activity trip, it is virtually certain that the school will be unable to provide medical care through the primary physician selected. In most cases when the student is away from the Eudora School District, no emergency care can be provided without this approval form.

**STOP: Must be signed in presence of a Notary Public:**

Signature of parent/guardian \_\_\_\_\_ Date signed \_\_\_\_\_

State of Kansas, County of \_\_\_\_\_

SEAL

Subscribed and sworn to before me this \_\_\_\_\_

Day of \_\_\_\_\_, 20\_\_\_\_.

My commission expires: \_\_\_\_\_

(Notary Public)

**Refusal to Consent**

I DO NOT give consent for emergency medical treatment of my child. I understand that by signing "Refusal to Consent," my child WILL NOT be allowed to participate in field trips or activities outside of the district.

Signature of parent/guardian \_\_\_\_\_ Date signed \_\_\_\_\_