

**CLOVIS MUNICIPAL SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION**

GEN 591

PURPOSE: To enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached and to authorize the release of medical information to school officials/employees who have responsibility for the student while the student is at school or a school event and/or is being transported by the schools.

Student Information

Name _____ Student Cell # _____
Last First Middle
 School _____ Grade _____ Teacher _____ Bus # _____
 Date of Birth _____ Social Security Number _____
 Home Address _____ Home Phone _____
Legal Guardian's Full Name _____ **Cell Number** _____
 Place of Employment _____ Phone Number _____
 Email address _____
Legal Guardian's Full Name _____ **Cell Number** _____
 Place of Employment _____ Phone Number _____
 Email Address _____

Is there a Legal Custody order that applies to this child? (Please Circle) Yes No
 If "Yes", please give details _____

Health insurance Information

Please check the type of health insurance your child has: Private Medicaid None

Emergency Contacts (will be called if parent/guardian **CAN NOT** be reached)

1. Name	Relationship	Phone	Cell
2. Name	Relationship	Phone	Cell
3. Name	Relationship	Phone	Cell
4. Name	Relationship	Phone	Cell

Emergency Care Information

Physician	Phone	Fax
Dentist	Phone	Fax
Nurse Practitioner/Physician Assistant	Phone	Fax
Hospital	Phone	Fax

Consent

In the event of an emergency involving my child, and after reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the transport of my child to the above mentioned medical providers and/or hospital, and authorize these providers and hospital to administer any reasonable and customary medical and health care deemed necessary.
 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.
 Nothing in this section shall be constructed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.
 It is understood that I will be financially responsible for all emergency care.
I understand that it is my responsibility to notify the school immediately of any information on this form that changes.

Parent/Legal Guardian Signature _____ **Date** _____

Please complete Signature Card on the back of this form

CLOVIS MUNICIPAL SCHOOLS SIGNATURE CARD

PURPOSE: To ensure that only adults authorized by you, the Parent or Legal Guardian, may take your child from school.

Student Information

Name _____
Last
First
Middle

School _____ Grade _____ Teacher _____

Parent/Legal Guardian please sign in the space provided below and return this form to school as soon as possible. You DO NOT need to collect signatures from others you list below – school authorities will verify identity and obtain signatures at the time these individuals check your child out of school.

Parent/Guardian Signature	Relationship
Printed Name	Phone #
Parent/Guardian Signature	Relationship
Printed Name	Phone #
Signature	Relationship
Printed Name	Phone #
Signature	Relationship
Printed Name	Phone #
Signature	Relationship
Printed Name	Phone #
Signature	Relationship
Printed Name	Phone #

Other Siblings in the Family

Name	Age	Grade	School
Name	Age	Grade	School
Name	Age	Grade	School
Name	Age	Grade	School
Name	Age	Grade	School

It is the responsibility of the Parent/Legal Guardian to update this information immediately should changes occur.