Common Ground Christian Church

Emergency Medical Authorization (5341 F1)

Student's Name: _____ Date of Birth: _____ Grade: _____
Address: _____ Home Phone: _____

PURPOSE: to enable parents and guardians to authorize the provision of emergency treatment of children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Make sure to # in order** how you would like to us to call your contact list otherwise we will start at the top and go down the list.

Order to Attempt Contact **EMERGENCY PHONE NUMBERS**

_____ Mother's Name _____ Cell # _____

_____ Mother's daytime place of work: _____ Number (ext.) _____

_____ Father's Name _____ Cell # _____

_____ Father's daytime place of work: _____ Number (ext.) _____

_____ Relative Name _____ Relationship _____ Number(s) _____

_____ Other Name _____ Relationship _____ Number(s) _____

IMPORTANT MEDICAL INFORMATION: DO NOT LEAVE blank

ALLERGIES: Yes or No LIST: _____ REACTION: _____ EPI PEN: Yes or No

If a FOOD Allergy, what food items MUST be AVOIDED: _____

ASTHMA: Yes or No LIST TRIGGERS: _____ INHALER: Yes or No NEBULIZER: Yes or No

DIABETES: Yes or No DATE DIAGNOSED: _____ MANAGEMENT: Inhaler or Insulin Pump

SIEZURES: Yes or No LAST SIEZURE: _____ TRIGGERS: _____ DIASTAT: Yes or No VNS: Yes or No

ADHD: Yes or No ADHD Medication - Med Name: _____ Dose: _____ Time Given: _____

VISION ISSUES (circle): Nearsighted Farsighted Astigmatism Lazy Eye Legally Blind Other: _____

CHILD WEARS (circle): Glasses Contacts Hearing Aid HEARING ISSUES: Yes or No LIST: _____

OTHER MEDICAL CONDITIONS: Yes or No LIST: _____

PRESCRIPTION Medications to be given, MUST have a Doctor Order & Medication must be in original container & brought in by an ADULT, BEFORE a Chaperone can administer the medication

PART I OR PART II MUST BE COMPLETED

PART I: To Grant Consent

Physician: _____ Phone: _____ Dentist: _____ Phone: _____

Hospital: _____ ER #: _____ Specialist: _____ Phone: _____

In the event reasonable attempts to contact me at the numbers above have been unsuccessful, I HEREBY GIVE MY CONSENT FOR (1) administration of any treatment deemed necessary by above physician or above dentist 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.

Signature of Parent/Guardian: _____ Date: _____

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 church authorities to TAKE NO ACTION OR TO_____

Signature of Parent/Guardian: _____ Date: _____

PARENT PERMISSION FORM
2021

I hereby grant permission for my son/daughter _____ to attend **any event/church function** sponsored by **Common Ground Christian Church** during the year of 2021.

I will not hold the church, the organization, its leaders or advisors, or the adults driving to the event responsible in case of accident.

Daytime Phone: _____ Contact #: _____

Name of doctor: _____ Phone #: _____

Signature: _____ Date: _____

Parent/Guardian

Parent Email: _____