EMERGENCY MEDICAL AUTHORIZATION

LIBERTY LOCAL SCHOOL DISTRICT

www.libertylocalschools.org

STUDENT'S LAST	FIRST	MIDDLE	BIRTHDATE ☐ MALE ☐ FEMALE
MOTHER'S FULL NAME	PHONE NUMBER	FATHER'S FULL NAME	PHONE NUMBER
STUDENT ADDRESS			
PARENT/GUARDIAN EMAIL ADDRESS:			
TEACHER		GRADE	ROOM NUMBER
SCHOOL (Check One) ☐ Liberty (PK-6)	☐ Liberty Jr. High (7/8)	☐ Liberty High School (9-12)	
PARENT'S ARE (Check one) ☐ MARRIED	☐ DIVORCED	☐ SEPARATED	☐ NEVER MARRIED
IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE COMPLETE THE FOLLOWING SECTION:			
FULL NAME OF PERSON WHO HAS LEGAL CUSTODY OF CHILD		RELATIONSHIP	PHONE NUMBER

EMERGENCY CONTACTS (INCLUDE PARENT/GUARDIAN & ALL OTHER CONTACTS)

THE LIBERTY SCHOOL'S STAFF WILL CONTACT THE PERSONS LISTED BELOW **IN ORDER.** IF THE CONTACT IS UNAVAILABLE, THE NEXT PERSON WILL BE CALLED. **THE STUDENT WILL ONLY BE RELEASED TO PERSONS LISTED BELOW.**

Name	Relationship to child	Address	Phone numbers a. or b.
Name	Relationship to child	Address	Phone numbers a. or b.
Name	Relationship to child	Address	Phone numbers a. or b.
Name	Relationship to child	Address	Phone numbers a. or b.
Name	Relationship to child	Address	Phone numbers a. or b.
Name	Relationship to child	Address	Phone numbers a. or b.

STUDENT'S NAME	GRADE

STUDENT'S SIBLINGS: Please list the first name, last name, and grade of this student's brothers and sisters.

FIRST & LAST NAME	GRADE
FIRST & LAST NAME	GRADE
FIRST & LAST NAME	GRADE
FIRST & LAST NAME	GRADE

MEDICAL CONSENT--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 the above-named doctor, 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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

PHYSICIAN	PHONE
DENTIST	PHONE
MEDICAL SPECIALIST	PHONE
PREFERRED HOSPITAL	PHONE

Please list the facts concerning the child's medical history, including allergies, medications, and any physical impairments to which a physician should be alerted.

SIGNATURE OF PARENT/GUARDIAN	DATE

REFUSAL TO CONSENT --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 school authorities to take the following actions:

SIGNATURE OF PARENT/GUARDIAN	DATE

ADDRESS CHANGES--Address changes throughout the school year will require proofs of residency.