

# Union Local School District

## Emergency Medical Authorization Form

GRADE \_\_\_\_\_

AM BUS # \_\_\_\_\_

PM BUS # \_\_\_\_\_

Building \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

### **Student Information**

Student Name \_\_\_\_\_ Student Birth Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Student Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

### **Health Information**

Allergies \_\_\_\_\_

Preferred treatment for allergies \_\_\_\_\_

(If this includes medication of any type, please send a supply to the school nurse)

Chronic medical problems \_\_\_\_\_

Medication taken every day \_\_\_\_\_

Prior hospitalizations/surgeries \_\_\_\_\_

Other health information the nurse should know \_\_\_\_\_

(Please attach note if health history is lengthy)

### **Contact Information (Should your child become ill at school and we can't reach the parent/guardian)**

Please list contact information in the order you would like the calls to be made:

Name	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

### **Siblings that attend Union Local:**

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_

2. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_

3. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_

I hereby give consent for the following medical care providers and local hospital to be called:

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

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

Emergency Room

Local Hospital \_\_\_\_\_ Phone( ) \_\_\_\_\_

**I give permission for school personnel to administer Tylenol or Tums as needed. Yes \_\_\_ No \_\_\_**

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 above-named doctors, 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 performance of such surgery.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

# Union Local School District

GRADE \_\_\_\_\_

AM BUS # \_\_\_\_\_

PM BUS # \_\_\_\_\_

## Bus Transportation Information Form

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Gender

\_\_\_\_\_  
School Building

\_\_\_\_\_  
Morning Bus

\_\_\_\_\_  
Afternoon Bus

\_\_\_\_\_  
House Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Apt # or Lot #

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell/ Work Phone

.....  
\_\_\_\_\_  
**Morning Pick-Up Address (If different from home address)**

MON\_\_ TUES\_\_ WED\_\_ THU\_\_ FRI\_\_

\_\_\_\_\_  
Contact Name and Phone Number at this address

Bus # \_\_\_\_\_

.....  
\_\_\_\_\_  
**Afternoon Drop-off Address (If different from home address)**

MON\_\_ TUES\_\_ WED\_\_ THU\_\_ FRI\_\_

\_\_\_\_\_  
Contact Name and Phone Number at this address

Bus # \_\_\_\_\_

.....  
\_\_\_\_\_  
**Emergency Dismissal Drop-Off (If different from home address)**

MON\_\_ TUES\_\_ WED\_\_ THU\_\_ FRI\_\_

\_\_\_\_\_  
Contact Name and Phone Number at this address

Bus # \_\_\_\_\_

.....  
**Siblings that attend Union Local**

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_

2. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_

3. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_