Butler Tech

EMERGENCY MEDICAL AUTHORIZATION

Student Name _____ **DOB** _____ **Grade** _____ **Called Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Student Cell Phone** _____ **Student Email** _____

School Name _____ **Program** _____ **Home School** _____

Parent/Guardian 1 **Relationship** _____

Name _____ **Cell Phone** _____

Address _____, _____ **Home Phone** _____

Email Address _____ **Work Phone** _____

Parent/Guardian 2 **Relationship** _____

Name _____ **Cell Phone** _____

Address _____, _____ **Home Phone** _____

Email Address _____ **Work Phone** _____

*If applicable, please indicate who has custody of the student and provide custody papers. _____

Person(s) who may be notified and to whom your child may be released if the school cannot reach you:

1. _____ **Relationship** _____ **Phone** _____
2. _____ **Relationship** _____ **Phone** _____
3. _____ **Relationship** _____ **Phone** _____
4. _____ **Relationship** _____ **Phone** _____
5. _____ **Relationship** _____ **Phone** _____
6. _____ **Relationship** _____ **Phone** _____

☐ **Daily Meds at Home:**
☐ **Daily Meds at School:**
☐ **Rescue Meds:**

Medical Problems/Allergies/Special Needs to which a physician should be alerted:

☐ Allergy	☐ Chronic Illness/Disorders	☐ Hearing Impaired	☐ Surgeries
☐ Anaphylaxis	☐ Diabetes	☐ Heart Condition	☐ Visually impaired
☐ Asthma	☐ Dietary Restrictions	☐ Orthopedic	☐ Other
☐ Bleeding Disorders	☐ Emotional Problems	☐ Seizures	

Please Describe

Please note: If your student needs to take any medication while at school, a parent/guardian will need to complete a separate authorization form located on our website and submit to your child's campus office. A prescribed medication will also require the prescriber's authorization.

The Student Health Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.	

Preferred Doctor _____ **Phone** _____
Preferred Dentist _____ **Phone** _____
Preferred Hospital _____ **Phone** _____

Please select one of the following below concerning medical treatment for your child:

TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctor or in the event the designated preferred practitioner is not available by another licensed physical or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other license physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

TO REFUSE 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 NO action or to:

		03-11-2025 12:01:47 PM
Consent Selection	**Signature of Parent/Legal Guardian**	**Date**