EMERGENCY PROCEDURE CARD FOR COVENTRY LOCAL SCHOOLS

SIDE ONE

Both sides must be complete AND signed. Please use BLUE or BLACK Ink and PRINT LEGIBLY.

Student Name:________________________ Grade:_____ Homeroom Teacher:______________

Home Address:____

City: ____________________ ZIP: __________ *Home Phone: ______________________ Unlisted Y/N

Please Note: The phone number you enter on this line will be used as the PRIMARY number in our student data system and in our Parent Notification system. It is the number that will be called for both emergency and non-emergency messages. If this information changes during the school year, please contact the building secretary. Thank you.

EMERGENCY CONTACT

CHILDREN MAY ONLY BE RELEASED TO THOSE INDIVIDUALS LISTED ON THIS CARD. THE ORDER IN WHICH CONTACTS ARE LISTED IS THE ORDER USED WHEN CALLING HOME FOR EMERGENCIES (I.E. SICKNESS).

First Parent Contact:

__*Mr.* __*Mrs.* __*Miss* __*Ms.*

First Name: ____________________ Last Name:____________________ Relationship:____________

Address:______________________________________ City:____________________ ZIP:__________

Email:____

Home Phone: ______________ Cell Phone: ____________________ Business Phone:______________.

Second Parent Contact:

__Mr. __Mrs. __Miss __Ms.

First Name: ____________________ Last Name:____________________ Relationship:____________

Address:______________________________________ City:____________________ ZIP:__________.

Email:____

Home Phone: ______________ Cell Phone: ____________________ Business Phone:______________

If mother/father is separated, is there a problem with contacting other parent? Y / N

TWO Alternate Contacts: *If additional contacts are necessary, you may contact your school office.*

__Mr. __Mrs. __Miss __Ms.

First Name: ____________________ Last Name:____________________ Relationship:____________

Daytime Phone:__________________________

__Mr. __Mrs. __Miss __Ms.

First Name: ____________________ Last Name:____________________ Relationship:____________

Daytime Phone:__________________________

Date:__________ Signature of Guardian/Parent:______________________________

Turn over and complete the back side.

Revised: 2/2010

SIDE 2: EMERGENCY MEDICAL AUTHORIZATION FORM COVENTRY SCHOOLS

***Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.*

STUDENT NAME:________________________________ SCHOOL: __________ GRADE:____ BIRTHDATE:________

PART I or PART II MUST BE COMPLETED

PART I – To Grant Consent: I hereby *give consent* for the following medical providers and local hospital to be called:

DOCTOR____ PHONE________________________

DENTIST____ PHONE________________________

LOCAL HOSPITAL______________________________________ PHONE________________________

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 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 medial opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Please include any health information that physicians or school officials should know:

Health Problems: ____
(Include allergies, especially bee sting allergy/other life threatening allergies)

Medications taken daily: ____
(Give names of medications and dosages)

SIGNATURE OF PARENT / GUARDIAN____________________________________ DATE____________

ADDRESS:____ CITY:________________ ZIP:__________

PART II – Refusal to Consent: IF YOU DO NOT GIVE CONSENT FOR EMERGENCY TREATMENT

I *do not give my consent* for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

SIGNATURE OF PARENT / GUARDIAN____________________________________ DATE____________

ADDRESS____ CITY:________________ ZIP:__________