

## Jesup Elementary Programming

**\*\*PLEASE BE SURE TO FILL OUT ALL SECTIONS\*\***

Parental Emergency Medical Consent. This form must be presented upon admission for treatment.

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact me at \_\_\_\_\_ (Phone #) or \_\_\_\_\_ (Phone #) have been unsuccessful, I hereby give the consent for the administration of any treatment deemed necessary by Doctor \_\_\_\_\_ (physician) at \_\_\_\_\_ (Phone#) or Doctor \_\_\_\_\_ (dentist) at \_\_\_\_\_ (Phone #) or in the event the designated practitioners are not available, than by another licensed physician or dentist; and the transfer of the child to \_\_\_\_\_ (preferred hospital).

### 1. Parents/Guardians/Custodians with Whom the Child Resides:

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Home # \_\_\_\_\_ Cell# \_\_\_\_\_  
Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
Work # \_\_\_\_\_ Work Hours \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
Work # \_\_\_\_\_ Work Hours \_\_\_\_\_

### 2. Persons to Contact In Case of Emergency If Parents Are Unavailable, and are Authorized to Pick Up Child:

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
Work # \_\_\_\_\_ Work Hours \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
Work # \_\_\_\_\_ Work Hours \_\_\_\_\_

(TURN OVER)

3. In the event the Parents/Guardians listed above can not pick up the listed child, all of the following have my permission to pick the given child up while in the care of Jesup Community School:

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

4. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in our care?

\*Name \_\_\_\_\_

\*Name \_\_\_\_\_

### 5. Information

Physician Name \_\_\_\_\_ Dentist Name \_\_\_\_\_  
Street address \_\_\_\_\_ Street address \_\_\_\_\_  
City, State \_\_\_\_\_ City, State \_\_\_\_\_  
Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Last Tetanus \_\_\_\_\_ Known Allergies \_\_\_\_\_  
Present \_\_\_\_\_  
Medication \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Holders I.D. \_\_\_\_\_

This Consent will be in effect for One Year beginning (date) \_\_\_\_\_

Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_