# Pymatuning Valley Schools
# Emergency Medical

**Student's Full Legal Name: ______________________________________________________GRADE______ BUS # ______**

**Parent's Primary Phone #:_____________________________________ Parents Cell #_________________________________**

**Student's Primary Address________________________________________________________________________________**
**Street address P.O. Box City State Zip**

**Parent's Email Address________________________________________________________________________________**
**(Student and School information will be sent to this address)**

Does the student live with both biological parents (mother and father) Yes_______ No________
If no, who is residential parent ______________________________________ (custody papers must be provided)

| Mother's Name | Workplace | Phone # |
|---|---|---|
| Father's Name | Workplace | Phone # |
| Step Mother's Name | Workplace | Phone # |
| Step Father's Name | Workplace | Phone # |

**Father's Military Background**
1) Are you currently serving in the military? ___Yes ___No ___Retired

**Mother's Military Background**
1) Are you currently serving in the military? ___Yes ___No ___Retired

**Please list other family members that attend PV school district:**

_________________________ _________________________ _________________________ _________________________

**CONTACT PERSON OTHER THAN RESIDENTIAL PARENT/GUARDIAN: (Two contacts required)**
**Purpose: For parents to authorize the provisions of emergency medical treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.**

Name: ________________________________Relationship________________________Phone:______________________

Name: ________________________________Relationship________________________Phone:______________________

****During the 2020-2021 School Year, if we have to enact our Remote Learning Plan, my child will be:**
**________Internet Learner**
**________Paper Packet Learner**

**PART I OR II MUST BE COMPLETED**

## PART I - TO GRANT CONSENT

**I hereby give consent for the following medical care providers and hospitals to be called:**

**Doctor:**__________________________________________________ **PHONE:**______________________________

**Dentist:**__________________________________________________ **PHONE:**______________________________

**Preferred 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 medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

**Please list any allergies or medications being taken and or any medical concerns:**

________________________________________________________________________________________________

**DATE:** __________________________ **SIGNATURE OF PARENT/GUARDIAN:**________________________________________

## PART II - 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 action:

**DATE:** ____________________________ **SIGNATURE OF PARENT /GUARDIAN:**________________________________________

**Revised 8/6/20**