DISTRICT EMERGENCY CONTACT AND MEDICAL AUTHORIZATION FORM

SCHOOL: ______________________________ **SCHOOL YEAR:** __________

STUDENT INFORMATION

First Name:	Last Name:	Date of Birth: / /
Grade:	Homeroom Teacher:	Homeroom Classroom Number:
Home Address Street:	City:	ZIP:
Student Cell Phone Number: ( )	Student Email:	

Who does the student live with? Select all that apply:

☐ Mother ☐ Father ☐ Guardian ☐ Grandparent ☐ Other Relative ☐ Other ____________

EMERGENCY CONTACTS INFORMATION

PRIMARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other ____________

SECONDARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other ____________

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other ____________

EMERGENCY CONTACTS INFORMATION - CONTINUED

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other ____________________

SIBLINGS IN STUDENT'S HOME

Please list all siblings in student's home (include non-school age children)

Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /

CONSENT TO CONTACT MEDICAL CARE PROVIDERS / HOSPITALS

PART 1 - TO GRANT CONSENT

Only Part 1 or Part 2 below must be completed and signed.

Doctor's Name:	Phone: ( )	Address:
Dentist's Name:	Phone: ( )	Address:
Medical Specialist (optional):	Phone: ( )	Address:
Local Hospital:	Emergency Room Phone: ( )	Address:

Emergency Medical Authorization I hereby give permission for a physician, licensed nurse, or other school employee designated by school administration, to administer medical treatment to my child in an emergency, including as a result of athletic participation, that threatens the life or health of my child. I understand that school staff and medical personnel will be acting in good faith, in accordance with applicable law and in the best interest of my child. DPSCD staff will adhere to applicable policies as well. By providing this consent, to the extent permitted by law, I voluntarily with full knowledge of its significance, release and hold harmless DPSCD, the Board of Education and its staff, contractors, agents, and volunteers from liability resulting directly or indirectly from the medical treatment provided. I further authorize a physician, licensed nurse or other school employee designated by school administration to cause my child to be transported to the nearest hospital for treatment in an emergency. I hereby assume responsibility for the costs of any medical treatment and transportation provided to my child which may include indemnification of DPSCD for such costs.

Signature of Parent/Guardian:______________________________ Date______________

Note: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.

PART 2 - REFUSAL TO CONSENT

Do not complete Part 2 if you completed Part1.

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 school/district authorities to take the following action:

Signature of Parent/Guardian:______________________________ Date______________

DPSCD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, transgender identity, disability, age, religion, height, weight, citizenship, marital or family status, military status, ancestry, genetic information, or any other legally protected category, in its educational programs and activities, including employment and admissions Questions? Concerns? Contact the Civil Rights Coordinator at (313) 240-4377 or dpscd.compliance@detroitk12.org or 3011 West Grand Boulevard, 14th Floor, Detroit MI 48202.