FUCHS MIZRACHI SCHOOL

2021-22 Emergency Medical and Legal Authorization Form

Please provide the information below for your children in grades 1 through 12. Return to the Front Office when completed.

Student Information:

Student Name:		Grade:		Date of Birth:	
Student Name:		Grade:		Date of Birth:	
Student Name:		Grade:		Date of Birth:	
Student Name:		Grade:		Date of Birth:	
Student Name:		Grade:		Date of Birth:	
Student Home Address:					

Student Guardianship/Parent Information:

Parent/Guardian Name:		Mobile #:		Other #:	
Parent/Guardian Name:		Mobile #:		Other # :	
Non-Custodial Parent Name:		Mobile #:		Other# :	
Is there a restraining order?		*If Yes, submit a copy of the Court's Order to the school office*			

Emergency Contact Information:

Emergency Contact Name:		Relationship:		Best Phone #:	
Emergency Contact Name:		Relationship:		Best Phone #:	

Student Medical History, Health Status, Allergies, Medications and/or Physical Limitations:

By indicating "Yes "below, you give your consent for the school nurse to administer either Tylenol or Advil to your child(ren) based on your first preference.

Student Name	Health Issues/Physical Limitations/Prescribed Medications	Prefer *Advil	Prefer *Tylenol

I give consent for the school nurse to administer Advil or Tylenol.

In the event that reasonable attempts to contact me or the other persons listed on this form have been unsuccessful: Check One (Grant or Deny) below, sign and date.

- ☐ **I GRANT PERMISSION** for the administration of any treatment deemed necessary by the medical professional listed below. *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 the hospital listed below.*

- ☐ **I DENY PERMISSION** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I instruct the school authorities to take the following action(s):___________________________

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Doctor's Name:		**Dentist's Name:**	
Doctor's Phone:		**Dentist's Phone:**	
Hospital of Choice:			

Signature or eSignature of Parent/Guardian:			
Printed First and Last Name:		**Date:**	