

EMERGENCY MEDICAL AUTHORIZATION

_____	_____	_____
School District	Student Name	Grade
RESIDENTIAL PARENT OR GUARDIAN		

Street Address		

Mother's Name _____	_____	_____
(Daytime Phone) _____	City	Zip
Father's Name _____	_____	_____
(Daytime Phone) _____	Telephone	_____
Other's Name _____	_____	_____
(Daytime Phone) _____	School Attended	_____
Name of Relative or Child Care Provider: _____	E-Mail Address: _____	_____

(Name)	(Address)	(Phone)	(Relationship)
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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.

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:

Doctor _____	Phone Number _____
Dentist _____	Phone Number _____
Medical Specialist _____	Phone Number _____
Local Hospital _____	Phone Number _____

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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date: _____ Signature of Parent/Guardian: _____

(Street Address) (City) (Zip)

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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: _____

(Street Address) (City) (Zip)