

Emergency Medical Authorization

Student Name: _____

Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Purpose - To enable parents(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent(s) or guardian(s) cannot be reached.

Residential Parents(s)/Guardian(s): _____ Phone: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Other's Name: _____ Phone: _____

Name of Relative of Children Provider: _____ Phone: _____

(PART I OR PART II MUST BE COMPLETED)

I hereby consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Med. Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent to the administration for any treatment deemed necessary by above named doctor, or in the event the designated practitioner is not available, by another licensed physician or dentist, concurring in the necessity for 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 dentist, 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 _____ Parent / Guardian Signature _____

Address _____

(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)

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 to take the following actions:

