EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT NAME _____ ADDRESS _____

_____

HOME PHONE _____

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.

RESIDENTIAL PARENT OR GUARDIAN

MOTHER'S NAME _____ PHONE _____
(FOR EMERGENCY)

FATHER'S NAME _____ PHONE _____
(FOR EMERGENCY)

OTHER'S NAME _____ PHONE _____
(FOR EMERGENCY)

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT

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

DOCTOR _____ PHONE _____

DENTIST _____ PHONE _____

SPECIALIST _____ PHONE _____

Facts concerning the student's medical history to which medical staff should be alerted.

- Please note: To insure student safety, information noted here may be shared with appropriate school staff.

Medical diagnosis (e.g. asthma, diabetes): _____

Allergies (food, meds, bees): _____

Medications taken regularly (include dosage): _____

In the event reasonable attempts to contact me have been unsuccessful, I herby 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.

_____

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

ADDRESS _____

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 to take the following action:

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

ADDRESS _____