

EMERGENCY MEDICAL AUTHORIZATION FORM

School _____ Student Name _____
Grade _____ Address _____
Date of Birth _____
Sex: _____ Male _____ Female Telephone _____

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 _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider:

_____ Relationship _____

Address _____ Daytime Phone _____

PART I OR II BELOW MUST BE COMPLETED

Part I: To Grant Consent

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

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administrations of any treatment deemed necessary by above-named doctors, 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 impairment to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____

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 authorities to take the following action:

Date _____ Signature of Parent/Guardian _____

Address _____