Grade to enter: _____

Emergency Medical Authorization

_____ Student Name_____

School district (*where you currently live.*)

Address_____

Student's Social Security Number

_____ 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_____

Emergency Contact Information

Name of relative or childcare provider

Relationship_____ Phone_____

Relationship_____ Phone_____

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_____ Address_____Phone_____

Dentist_____ Address_____ Phone_____

Medical Specialist_____ Address_____ Phone_____

Local Hospital_____ Address_____ Emergency Room Phone_____

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 unavailable, 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 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 include:

Date_____ Signature of Parent/Guardian _____

In addition to the parent/guardian, my child may be released to the following person(s). You are responsible for notifying the school office immediately should someone listed below no longer be permitted to pick up your child.

	Name	Address	Phone	Relationship
1.				
2.				

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_____