Grade Entering: _____

Emergency Medical Authorization

Student Name: _____ **School District of Residence:** _____

Address: _____ **Student Social Security Number:**

Phone: _____ _____ - _____ -_____

Purpose: *To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured whole under the 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: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

---------- PART 1 OR 2 MUST BE COMPLETED ----------

PART 1 – TO GRANT CONSENT

Doctor: _____ **Address:** _____ **Phone:** _____

Dentist: _____ **Address:** _____ **Phone:** _____

Medical Specialist: _____ **Address:** _____ **Phone:** _____

Local Hospital: _____ **Address:** _____ **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 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 include: _____

Signature of Parent/Guardian: _____ **Date:** _____

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

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

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 (written instructions must be completed:

_____

_____

Signature of Parent/Guardian: _____ **Date:** _____