EMERGENCY MEDICAL AUTHORIZATION

Student Name: ______________________________ **Address:** ______________________

School: ____________________ **Grade:** __________ **SS/ID #**____________________________

Purpose – To enable parents or 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: **(PLEASE INDICATE WHOM SHOULD BE CALLED FIRST)**

Mother/Step Mother: ________________ Daytime _________ Cell ___________ Work ___________

#_____ *Email address*: ____

Father/Step Father: ________________ Daytime _________ Cell ___________ Work ___________

#_____ *Email address*: ____

Guardian: ________________________ Daytime _________ Cell ___________ Work ___________

#_____ *Email address:* ____

Other/Relationship: ________________ Daytime _________ Cell ___________ Work ___________

#_____ *Email address:* ____

Child Care Provider:________________ Daytime _________ Cell ___________ Work ___________

#_____ *Email address*: ____

SUPPLEMENTAL INFORMATION

Student's date of birth: _________________________ Date of last Tetanus: ________________

Student resides with: (circle all that apply) Mother Father Step-Mother Step-Father Guardian
Other:___________________________________

Additional contact information for those who have authority to make decisions in an emergency situation involving this student. Please place in order of which to contact.

Name, Contact Information, and Relationship to the Student:

#1 ____

#2 ____

#3 ____

#4 ____

OVER

PART I *or* II MUST BE COMPLETED

PART I – TO GRANT CONSENT (If you are not granting consent, please refer to Part II)

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

Doctor: ______________________ 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 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 (2) 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:

Allergies: ____

Medications: ____

Physical Impairments: ____

Other pertinent information: ____

____

Date: ______________ **Signature of Parent/Guardian:** ______________________

Address: ____

Part II – REFUSAL of 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:

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Date: ______________ **Signature of Parent/Guardian:** ______________________

Address: ____