EMERGENCY MEDICAL AUTHORIZATION FORM

School _____ Student Name _____

Grade _____ Address _____

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. **Information provided on this form will be shared with school personnel who interact with your child to ensure his/her safety at school unless you note otherwise.**

Residential (lives with) Parent or Guardian:

(Designate – work or home)

Mother's Name _____ Daytime Phone _____
Father's Name _____ Daytime Phone _____
Guardian's Name _____ Daytime Phone _____

Name of (Local) Relative or Childcare Provider (circle one):
_____ Phone _____
Address _____

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 _____ Phone _____
Dentist _____ Phone _____
Preferred 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 the above-named doctor, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital 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.

IMPORTANT

Please list any facts concerning the child's medical history including allergies, medications being taken, current medical conditions, and any physical impairments to which the school and a physician should be alerted.

_____
_____
_____

_____ _____
Date Signature of Parent/Guardian

PART II – REFUSAL TO CONSENT
I do not give 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