SOUTHEAST LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION
(Use Black Ink)

_____Please check here if any of the information below has changed from the previous school year.

_____	_____	_____
Student Name	Home Phone	Teacher Name
_____	_____	_____
Street Address	City Zip	Grade
_____	_____	
Mother Name	Work Phone	Cell Email
_____	_____	
Father Name	Work Phone	Cell Email

****Please list all other names and phone numbers of people your child may be released to. List in the order you would like us to contact.**

_____		
Name	Phone Number	Relationship (ie: Sitter, Grandparent, Friend, Neighbor)
_____		
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_____		
Name	Phone Number	Relationship (ie: Sitter, Grandparent, Friend, Neighbor)

***YOU ARE RESPONSIBLE TO INFORM US OF ANY CHANGES**

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.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred physician) or Dr._____ (preferred dentist), or in the event the designated practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to _____ (preferred hospital) or 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 taken, and any physical impairments to which physician should be alerted:_____.

_____	_____	_____
Printed name of Custodial Mother/Guardian	**Signature** of Custodial Mother/Guardian	Date
_____	_____	_____
Printed name of Custodial Father/Guardian	**Signature** of Custodial Father/Guardian	Date

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II REFUSAL TO CONSENT

I do not give my consent for emergency treatment for my child. In the event of illness or injury requiring treatment, I wish the school authorities take no action or to:_____.

_____	_____	_____
Printed name of Custodial Mother/Guardian	**Signature** of Custodial Mother/Guardian	Date
_____	_____	_____
Printed name of Custodial Father/Guardian	**Signature** of Custodial Father/Guardian	Date