EMERGENCY MEDICAL AUTHORIZATION FORM

PURPOSE: To provide vital contact information and to enable the parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, in the event the parents cannot be reached.

STUDENT: ________________________________ DOB: ____/____/____ Grade: _______School: ________________

Phone (C): ____________ E-Mail: ____

MOTHER: ________________________ Phone (H): ____________________ Phone (W): ____________________

Phone (C): ____________________ E-Mail: ____

FATHER: ________________________ Phone (H): ____________________ Phone (W): ____________________

Phone (C): ____________________ E-Mail: ____

EMERGENCY CONTACT:

Name: ______________________________________ Relation: _________________ Phone (H): ____________

Phone (W): ________________________ Phone (C): ______________________

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

Doctor: ____ Phone: ____________________________________

Dentist: ____ Phone: ____________________________________

Medical Specialist: ___________________________________ Phone: ____________________________________

I prefer to have my child transported to _________________________________ hospital or any hospital reasonably accessible.

In the event reasonable attempts to contact me have unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by above name doctor(s), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of my child to an appropriate hospital. This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

MEDICAL ALERTS: Facts concerning my child's medical history including medications, allergies, impairments, past surgery, etc.

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SIGNATURE OF PARENT/GUARDIAN

____ Date: _________________

REFUSAL TO CONSENT:
I do not give my consent for emergency 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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SIGNATURE OF PARENT/GUARDIAN

____ Date: _________________

Revised 7-10