Student's Name _____

Authorization
For medical treatment of minors

If your child needs medical, dental, health, of hospital services, you as parent must give permission. It's the law. What about times when you cannot be reached for permission? A Child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health. Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child. You can prepare for unexpected care your children might need when you are away from home.

To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed. This is a legal document. With it you may appoint relatives, friends, teachers, clergy, and neighbors – anyone who is over 18 years of age – to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you. Fill out this form carefully. Have your signature witnessed by an adult different from the person you are making responsible for your children. After you complete this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person- physician, dentist or hospital representative.

NAME OF MINORS	BIRTHDATES	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I/we, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

NAME	ADDRESS	PHONE
Syracuse City School District Staff	**309 W Brighton Ave, Syracuse, NY 13205**	**315-435-4535**
NAME **Contact Community Service Staff**	ADDRESS **6311 Court Street Road East Syracuse NY 13057**	PHONE **315-251-1400**
NAME	ADDRESS	PHONE

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:

MONTH	DAY	YEAR		MONTH	DAY	YEAR
July	7	2014	through	August	8	2014

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

PARENT/GUARDIAN		PARENT/GUARDIAN	
SIGNATURE		SIGNATURE	
ADDRESS	DATE	ADDRESS	DATE
WITNESS		**WITNESS**	
SIGNATURE		SIGNATURE	
ADDRESS	DATE	ADDRESS	DATE

Insurance Information

INSURANCE COMPANY OR GOVERNMENT PROGRAM	I.D. OR CONTRACT NUMBER

FAMILY PHYSICIANS:

NAME AND PHONE NUMBER	NAME AND PHONE NUMBER

Special Medical Notes:

_____

_____ _____

(Parent/Guardian Signature) *(Student's Signature)*