EMERGENCY MEDICAL AUTHORIZATION

Student Name ___________________________________ Telephone _________________

Address ____ Home School ________________

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 at ______________________________ (phone number) or

__________________________________ (other parent or guardian) at ____________________________ (phone number)

have been unsuccessful. I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ____________________ (preferred physician) or Dr. _____________________ (preferred dentist), 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 _____________________________________ (preferred hospital) or any hospital reasonably accessible.

_________ ______________________________ ____

Date Signature of Parent or Guardian Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II REFUSAL TO 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 to the school authorities to take no action or to:

____

_________ ______________________________ ____

Date Signature of Parent or Guardian Address

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PART III

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 being taken, and any physical impairments to which a physician should be alerted:

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_________ ______________________________ ____

Date Signature of Parent or Guardian Address