Emergency Medical Authorization Form

Student's name _____ Birth date _____

Student's address _____

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.

Residential Parents or Guardians

Parent/Guardian name _____ Daytime phone _____

Parent/Guardian name _____ Daytime phone _____

Part I or II must be completed

Part I: To grant consent. I hereby grant consent for the following providers and local hospital to be called:

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

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 above-named doctors, 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 any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion 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 my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

Date _____ Signature of parent/guardian _____

Part II: Refusal to grant 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 the school to take the following action:

_____

_____

_____

Date _____ Signature of parent/guardian _____