EMERGENCY MEDICAL AUTHORIZATION

Student Name:_____ Date of Birth:_____

Address:_____

Telephone:_____

Residential Parent or Guardian:

Mother living with family? ☐Yes ☐No Father living with family? ☐Yes ☐No

Mother Name:_____ Father Name:_____

Primary Contact Phone #:_____ Primary Contact Phone #:_____

***Other Emergency Contact Person:**_____

Address:_____ Phone #:_____

Relationship to child:_____

Purpose: to authorize the emergency treatment for the above mentioned child who becomes ill or injured while under school authority when parents cannot be reached.

PART 1 (TO GRANT CONSENT)

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

Doctor:_____ Telephone:_____

Dentist:_____ Telephone:_____

Medical Specialist:_____ Telephone:_____

Local Hospital:_____ Telephone:_____

In the event reasonable attempts to contact me at _____ or other parent at _____ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr._____ (preferred doctor) or Dr._____ (preferred dentist); and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

The authorization does not cover major surgery unless the medical opinions of 2 other license physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:_____

_____

_____

_____

_____

Signature of Parent:_____ Date:_____

*******DO NOT COMPLETE PART 2 IF YOU HAVE COMPLETED PART 1*******

PART 2 (REFUSAL OF CONSENT)

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness of injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

_____

_____

Parent Signature:_____ Date:_____

Form Date: May, 2023