EMERGENCY MEDICAL AUTHORIZATION

Attending School _____ School District _____

Student Name _____ Date of Birth _____

Grade _____ Room _____ Telephone Number _____

Address _____ City _____ State _____ Zipcode _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached.

A. Residential Parent/Guardian

Mother's Name _____ Mother's Day Phone _____ Cell/Pager _____

Father's Name _____ Father's Day Phone _____ Cell/Pager _____

Other Name/Relationship _____ Other Day Phone _____

B. Name of Relative/Childcare Provider _____ _____

Name Relationship

_____ _____

Address Phone Number

*******PART I **OR** PART II MUST BE COMPLETED AND SIGNED *******

PART I MUST BE COMPLETED TO GRANT CONSENT: I Hereby give consent for the following medical providers/local hospital to be called.

Doctor's Name	Phone No.	Address
Dentist's Name	Phone No.	Address
Medical Specialist	Phone No.	Address
Local Hospital	E.R. Phone No.	Address

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 doctor, 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 any hospital reasonably accessible.

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.

Allergies & Reactions: _____

Medications Taken: _____

Chronic Physical/Behavior Problems: _____

Other: _____

Date: _____ Signature of Parent/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 the school authorities to take the following action.

_____

_____

Date _____ Signature of Parent/Guardian _____