Public School District you live in: ___________________________ Public School child would attend ______________________

EMERGENCY MEDICAL AUTHORIZATION

Student:____ Grade and Room: _____________________
(Last) (First) (Middle)

Date of Birth ________________________

Address: ____ Home Phone: ________________________

Mothers' Name: _______________________________________ Work Phone: _______________________________________

Fathers' Name: ____ Work Phone: _______________________________________

Cell Phone Numbers: Father ____________________________ Mother ____

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached.)

Name: ________________________________ Relation: _________________ Phone: ______________________________

Name: ________________________________ Relation: _________________ Phone: ______________________________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know.

____

____

Purpose: To enable parents or 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 One or Two Must be Completed

PART ONE: TO GRANT CONSENT

In the event reasonable attempts to contact me at home or at work or other parent or guardian have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:

Dr. ____________________________________ (preferred physician) Phone: _____________________________________

Dr. ____________________________________ (preferred dentist) Phone: _____________________________________

or, in the event the DESIGNATED preferred practitioner is not available, by another physician or dentist: and

2. The transfer of the child to ____________________________ (preferred hospital) Phone: ____________________________
or any other 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. A school official will accompany the child until a parent or guardian can be reached.

Signature of Parent or Guardian: ________________________________ Address: ____________________ Date: ________________

Do NOT complete Part Two if you have completed Part One.

PART TWO: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish school authorities to TAKE NO ACTION OR TO ____

____

Signature of Parent or Guardian: _______________________________ Address:_____________________ Date: ________________