EMERGENCY MEDICAL AUTHORIZATION

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.

Student's Name: ______________________________________ Birthdate:_______________________ Grade:____________

Home Address:____ Teacher/Homeroom: _______________________________

City/State/Zip:____ Date of Last Tetanus:___________________________

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other:____________________________

____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

___ Mother: ____________________________________ Home#:___________________ Work#: ___________________

___ Father: ____________________________________ Home#: ___________________ Work#: ___________________

___ Stepparent: _________________________________ Home#: ___________________ Work#: ___________________

___ Guardian: ___________________________________ Home#: ___________________ Work#: ___________________

___ Relative or alternate (i.e., child care provider), if applicable: Relationship to Child: _________________________________
Name: ___________________________________ Home#: ____________________ Work#: ________________________

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COMPLETE ONLY ONE OF THE FOLLOWING: **I**. Consent for Treatment **OR** **II**. Refusal to Consent

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

*Preferred Physician:*______________________________
Office #:____________________________________
*Preferred Dentist:*________________________________
Office #:____________________________________
*Medical Specialist:*_______________________________
Office #:____________________________________
*Preferred Hospital:*_______________________________
ER #:_______________________________________

AND

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:

____
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____
____

Parent/Guardian
Signature:____________________________________
Address:_____________________________________
____
Date:____

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 the preferred doctor indicated, 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.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

Parent/Guardian Signature: ____________________________________ Date:_____________