Emergency Medical Authorization Form

(Please print clearly)

Student_____

Address_____

_____

Phone number _____Social Security Number ____ - _____ -____

Purpose of this form – to enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parent/guardians cannot be reached.

Part I or Part II must be completed.

PART I (To Grant Request)

In the event reasonable attempts to contact me at _____ or
(phone)
_____ at _____ have been unsuccessful, I hereby give (other
parent/guardian) (phone)
my consent for (1) administration of any treatment deemed necessary by
Dr._____. Or in the event the designated preferred practitioner is not
(Preferred Physician)
available, by another licensed physician or dentist; and (2) the transfer of the child to
_____ or 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 before surgery is performed.

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

_____.

_____

Signature of parent Address Date

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 no action or to

_____

Signature of parent Address Date