EMERGENCY MEDICAL AUTHORIZATION

School ______________________ Student Name ______________________

Address ______________________

Tel ______________________

Residential Parent or Guardian

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

Mother ______________________ Daytime Tel ______________________

Father ______________________ Daytime Tel ______________________

Other Name ______________________ Daytime Tel ______________________

Relative or Childcare Provider ______________________ Tel ______________________

Address ______________________ Relationship ______________________

PURPOSE - To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

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

Doctor ______________________ Tel ______________________

Dentist ______________________ Tel ______________________

Medical Specialist ______________________ Tel ______________________

Local Hospital ______________________ Tel ______________________

In the event reasonable attempts to contact me at ______________ (tel #) or ______________ (other parent) at ______________ (tel #) 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), 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 ______________________ (preferred hospital) or any hospital reasonably accessible.

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

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Date	Signature of Parent	Address

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (REFUSAL OF 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:

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Date	Signature of Parent	Address