Emergency Medical Authorization Form

(please fill out with a pen)

School Year 2010-2011 Student Name_____

Grade ____ Age _____ Address_____

City_____Zip_____

Birthdate_____Telephone_____

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. This information is also a quick reference for emergency medical personnel.

Residential Parent or Guardian

Mother's Name_____Daytime Phone (_____) _____
Cell Phone_____

Father's Name_____Daytime Phone (_____) _____
Cell Phone_____

Other's Name_____Daytime Phone (_____)_____
Cell Phone_____

Parent E-mail address for correspondence (optional)_____

Name of Relative or Childcare Provider

_____
relationship

Address _____

City_____Zip_____

Daytime Phone (_____)_____

PART I or II MUST BE COMPLETED

Insurance Company: _____

Policy Number: _____

PART I: TO GRANT CONSENT

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

Physician _____Phone_____

Dentist _____Phone_____

Medical Specialist_____Phone_____

Local Hospital _____ Phone_____

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 to above-named doctors, 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:

_____

_____

Signature of Parent or Guardian_____

Address _____

City_____ Zip_____Date_____

DO NOT COMPLETE PART II **IF YOU COMPLETED** PART I

PART II: REFUSAL TO CONSENT

I do NOT give 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 or Guardian_____

Address_____

City_____ Zip_____