EMERGENCY MEDICAL AUTHORIZATION

5341F

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 contacted.

Student's Name:_____ Birth date:_____ 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#_____

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:

_____

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

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:

_____
_____
_____
_____

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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature_____ Date _____