

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. This information may be shared with the educational team to best meet your child's needs.

Student Name _____ Phone # _____ Bus # _____
 Address _____ School District _____
 _____ School Attending _____
 Sex M F Birth Date _____ Grade _____ Program _____

Residential Parent Or Guardian

Mother _____ Day Ph # _____ Cell # _____
 Father _____ Day Ph# _____ Cell # _____
 Other Name _____ Day Ph # _____ Cell # _____
 Name of Relative or Childcare Provider _____ Phone # _____
 Relationship _____ Address _____

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

Doctor _____ Phone # _____
 Dentist _____ Phone # _____
 Medical Specialist _____ Phone # _____
 Hospital _____ Phone# _____

Below check any current health condition that may require attention during the school day:

_____ Allergies (be specific)	_____ Concussion/head injury -- year _____
_____ Foods _____	_____ Physical Disability (be specific) _____
_____ Medicines _____	_____ Respiratory (be specific) _____
_____ Bee Stings _____	_____ Seizures _____
_____ Other _____	_____ Vision Problems _____
_____ Asthma	_____ Glasses _____ Contacts _____
_____ Cancer	_____ ADD/ADHD _____
_____ Diabetes	_____ Behavioral/Emotional Problems _____
_____ Hearing Problems _____ Hearing Aid(s) _____	_____ Other (be specific) _____
_____ Heart Problems (be specific) _____	
_____ Surgeries (include year) _____	

List all medications and dosages your child receives on a continual basis:

PLEASE COMPLETE PART I OR PART II --- NOT BOTH

Part I -- TO GRANT CONSENT

In the event reasonable attempt to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed Necessary by the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; And (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date _____ Parent or Guardian Signature _____

Part II --- REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness requiring emergency treatment, I wish the school Authorities to take no action or to: _____

Date _____ Parent or Guardian Signature _____