



EMERGENCY MEDICAL AUTHORIZATION FORM

SCHOOL _____ STUDENT NAME _____

HOMEROOM TEACHER _____ HOME PHONE NUMBER _____

ADDRESS _____ GRADE _____

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.

RESIDENTIAL PARENT OR GUARDIAN

STUDENT LIVES WITH: Both Parents Mother Father Other _____

MOTHER'S NAME _____
Daytime Phone _____ Work Phone _____ Cell _____

FATHER'S NAME _____
Daytime Phone _____ Work Phone _____ Cell _____

OTHER'S NAME
(If parents cannot be reached) _____
Daytime Phone _____ Work Phone _____ Cell _____

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT

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

DOCTOR _____ PHONE _____

DENTIST _____ PHONE _____

SPECIALIST _____ PHONE _____

Facts concerning the student's medical history to which medical staff should be alerted.

- Please note: To insure student safety, information noted here may be shared with appropriate school staff.

My child has major medical concerns: Yes No **If yes, explain** _____

Medical diagnosis (e.g. asthma, diabetes): _____

Allergies (food, meds, bees): _____

Physical impairments: _____

Does your child need medication to be kept at school for any of the above indicated medical concerns? Yes No

Medications taken regularly (include dosage): _____



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 above-named doctor, 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.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

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 the following action:

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

2/2/10
3/20/11
3/18/13