EMERGENCY MEDICAL AUTHORIZATION

Student Name _____ Home Phone _____
Address _____ School _____
E-mail address _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency medical treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I

TO GRANT CONSENT

In the event reasonable attempts to contact the following have been unsuccessful:

		Name	Phone
Parent/Guardian	1		
	2		
Nearest Relative	3		
Or Grandparents	4		

I hereby give consent for the administration of any treatment deemed necessary by:

Family Physician	1	
Family Dentist	2	

In the event the designated preferred physician is not available, I hereby give consent for treatment by any licensed physician or dentist.

I hereby give consent to allow my child to be transferred by Emergency Medical Services _____ or _____
Yes No
to _____ or 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. 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/guardian Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

Part II *Refusal* to Consent

I do not 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:

_____
_____
_____
Signature of parent/guardian Address