Print Form

EMERGENCY MEDICAL AUTHORIZATION FORM 2010-2011

STUDENT'S NAME _____ BIRTHDATE _____
(Last) (First) (Middle) (Month) (Day) (Year)
ADDRESS _____ PHONE (____)_____

PARENT CELL_____ **HOME EMAIL**_____

SCHOOL _____ **GRADE FOR 2010-11** _____ BOY _____ GIRL _____

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.

FATHER'S NAME _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____)_____

MOTHER'S NAME _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____)_____

LEGAL GUARDIAN _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____)_____

Living with: ___Parents ___Mother only ___Father only ___Other (specify) _____

Names of relatives or care providers who will assume care if your child becomes ill and neither parent or guardian can be reached.

1. NAME _____ PHONE (____)_____
   ADDRESS _____ RELATIONSHIP _____
2. NAME _____ PHONE (____)_____
   ADDRESS _____ RELATIONSHIP _____

PART I OR II BE COMPLETED

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 by 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:

_____

_____

Date _____ Signature of Parent/Guardian _____ Address

_____ Zip _____ CELL PHONE # _____

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 which the school authorities to take the following action:

_____

_____

Date _____ Signature of Parent/Guardian _____

Address _____ Zip _____ CELL PHONE # _____