

Emergency Medical Authorization
Part I-to grant consent

Grade _____

Student's Name _____
 Address _____
 Date of Birth _____
 Telephone _____ City _____ Zip _____
Residential Parent or Guardian*****

Mother _____ Phone _____ Phone _____
 Home Work
 Father _____ Phone _____ Phone _____
 Home Work
Relative/Child Care Provider*****

Name _____ Relationship _____
 Address _____ Phone _____
 City _____ Zip _____

Consent Section*****

In the event reasonable attempts to contact the above persons have been unsuccessful. I hereby give my consent for the following medical care providers and local hospital to be called:

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

Emergency Surgery*****

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 BEFORE THE SURGERY IS PERFORMED.

Special Medical History
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 _____

Do not complete Part II if you completed Part I
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:

 _____ Date _____ Signature of Parent _____

RETURN THIS FORM TO THE SCHOOL