EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name: _____ Birth Date: _____ Grade: _____

Address: _____ Student lives with: _____

City/Zip Code: _____ Home Phone Number: _____

PARENT/GUARDIAN(S) AND EMERGENCY CONTACTS

Call Order:	Relationship:	Name:	Day Phone:	Home Phone:	Cell Phone:	Can Pick Up:

Please indicate if your child has any of the following:

1) Allergies (please list): _____

2) Medications* (please list): _____

3) Inhalers* (please list): _____

4) Other medical concerns or conditions to which medical personnel should be alerted? _____

_____

_____

PART I *OR* PART II *MUST BE COMPLETED*

PART I: TO GRANT CONSENT **I hereby give consent for the following medical care providers and local hospital to be called:**

		Office Phone:	Address (Preschool only):
Physician:	_____	_____	_____
Dentist:	_____	_____	_____
Medical Specialist:	_____	_____	
Local Hospital:	_____	_____	

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 the appropriate medical professional; 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 for Grant to Consent **Date**

PART II: REFUSAL TO CONSENT

I do NOT give 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 for Refusal to Consent **Date**

Revised 6/1/11