

EMERGENCY MEDICAL AUTHORIZATION
2011-2012

_____	_____
STUDENT NAME	PARENT OR GUARDIAN
_____	_____
ADDRESS	TELEPHONE
_____	_____
GRADE	TEACHER
	SCHOOL

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.

PART I OR PART II MUST BE COMPLETED

Part I – To Grant Consent

In the event reasonable attempts to contact me at (phone no.) _____ or (other parent or guardian's name) _____ at (phone no.) _____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ / _____ or Dr. _____ / _____ (preferred physician) (phone no.) (preferred dentist) (phone no.) 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 _____ / _____ or any other (preferred hospital) (phone no.) 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 school personnel/physician should be alerted: _____

_____	_____
DATE	SIGNATURE OF PARENT OR GUARDIAN
	(MUST BE SIGNED)

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 _____ ADDRESS _____

HANDBOOK AUTHORIZATION

I have received a copy of the student handbook. _____YES _____NO

Student Name _____ Teacher Name _____

*

Parent Signature

Date

PLEASE RETURN THIS FORM TO THE SCHOOL