EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ Date of Birth _____ Grade _____ School Year _____

Address _____

(Street, City, & Zip)

MOTHER/GUARDIAN

Name _____

Email _____

Home Phone _____ Cell Phone _____

Work Place & Phone _____

FATHER/GUARDIAN

Name _____

Email _____

Home Phone _____ Cell Phone _____

Work Place & Phone _____

Is there a legal custody order that applies to this child? Yes _____ No _____ Copy of custody papers must be on file in office.

If yes, please explain _____

EMERGENCY CONTACTS

In addition to the parents/guardians listed above, please list people to whom you give permission to pick up your child from school. If we are unable to reach you, we will contact the people listed below in the order they are listed. Attach a list if you would like to include more.

	Name	Home #	Cell #	Work #	Relationship
1					
2					
3					

ALLERGIES- Please list all allergies including food, drugs, and/or environmental. State frequency, severity, and give details if emergency treatment may be required or if a physician should be altered. _____

_____

CURRENT HEALTH CONCERNS _____

_____

DAILY MEDICATIONS _____

_____

ADDITIONAL INFORMATION- Please include information that would be helpful to a health professional in case of emergency.

_____

Complete either Part I or Part II

PART I- CONSENT FOR TREATMENT

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 named doctor, or in the event the designated practitioner is unavailable, 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 to the performance of such surgery.

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor & Phone _____

Dentist & Phone _____

Hospital _____

Date _____

_____

Signature of Parent/Guardian

PART II- REFUSAL TO GRANT CONSENT FOR TREATMENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take the following action: _____

_____

_____

_____

Date _____

_____

Signature of Parent/Guardian