

Child's Full Name: _____

Home Phone #: _____

EMERGENCY MEDICAL AUTHORIZATION

Purpose—To enable parents and guardians to organize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Please indicate who should be called first:

Mother's Name: _____

Father's Name : _____

Pager #: _____

Pager #: _____

Cell Phone: _____

Cell Phone : _____

Emergency Contact if unable to reach parent:

Name: _____

Relationship: _____

Phone #: home _____ Cell: _____

Family Physician Name: _____

Phone Number: _____

Family Dentist Name: _____

Phone Number: _____

Preferred Hospital : _____

PART I: TO GRANT CONSENT

I hereby give 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 the performance of such surgery. Facts concerning the child's medical history, including allergies, medications taken, and any physical impairments to which a physician should be alerted:

Parent Signature

Date

PART II—TO REFUSE CONSENT:

I DO NOT give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to: _____

Parent Signature

Date