EMERGENCY MEDICAL AUTHORIZATION

Bus # _____

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

Students Name _____ Birthdate _____ Grade _____

Home Address _____ Teacher/Homeroom _____

Mailing Address _____ Date of last tetanus _____

City/State/Zip _____

Student resides with (circle all that apply) Mother Father Step-parent Guardian Other _____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact to be made based on availability.

___ Mother: _____ Home # _____ Work # _____ Cell # _____

___ Father: _____ Home # _____ Work # _____ Cell # _____

___ Step-Parent: _____ Home # _____ Work # _____ Cell # _____

___ Guardian: _____ Home # _____ Work # _____ Cell # _____

___ Other: _____ Home # _____ Work # _____ Cell # _____

Complete only one of the following: Consent for Treatment or Refusal for Treatment

I. Consent for treatment- I hereby give consent for the following medical care providers and local hospital to be called in the event of an emergency:

Preferred Physician: _____ Office Phone # _____

Preferred Dentist: _____ Office Phone # _____

Preferred Hospital: _____ ER Phone # _____

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 preferred doctor indicated, 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.

The 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.

Medical History: facts concerning the child's medical history including allergies, mediations being taken, and any physical impairment of which a physician and/or school personnel should be alerted: _____

_____

_____

Parent/Guardian Signature _____ Date _____

Email address _____

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 actions:

_____

_____

Parent/ Guardian signature _____ Date _____