

EMERGENCY MEDICAL AUTHORIZATION

Student Information:

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher / Team: _____

Mother: _____ Phone (day/night): _____ Cell: _____

(Circle one)

Father: _____ Phone (day/night): _____ Cell: _____

(Circle one)

Is there a legal custody order that applies to this child? Yes or No

If yes, please give details: _____

Emergency Contacts (if parent/guardian cannot be reached):

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Emergency Care Information:

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred Hospital: _____ Location: _____ Phone: _____

(Alternate hospital may be selected at the discretion of the responding Emergency Medical Services personnel)

Allergies and/or Specific Health Considerations: _____

Medications taken by student on a daily or frequent basis: _____

PART I – TO GRANT CONSENT

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 above-named doctor, 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 to the performance of such surgery.

Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian: _____ **Date:** _____

Address: _____

Student Signature (If 18 years or older) _____

PART II - REFUSAL TO CONSENT

(Complete only if action described above is refused)

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:

Signature of Parent/Guardian: _____ **Date:** _____

Address: _____

Student Signature (If 18 years or older) _____