EMERGENCY MEDICAL AUTHORIZATION

New Address ☐

School District _____

Student _____

Address _____

Phone _____

Person who will care for child when parent cannot be reached:

NAME ADDRESS PHONE

1. _____

2. _____

Work Phone Mother _____ Father _____

Cell Phone Mother _____ Father _____

Parent Email _____

Birth Date _____

Purpose— To enable parent 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.

The school nurse or principal has my permission to administer non-aspirin pain reliever to my child (please circle one)

YES NO

_____

Parent's Name (please print)

BROTHERS AND SISTERS

Name _____ Grade _____

_____

_____

_____

Part I *to Grant Consent* - In the event reasonable attempts to contact me at the above phone numbers have been unsuccessful, **I hereby give my consent** for:(1)the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____ (preferred dentist, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and(2) the transfer of the child for treatment to _____ (preferred hospital) or any hospital reasonably accessible.

Military Status (If applicable): ☐ Mother ☐ Father ☐ Active ☐ Inactive ☐ Guard ☐ Reserve ☐ NA	Military Branch: ☐ Army ☐ Air Force ☐ Marines ☐ Navy ☐ Coast Guard
Military Status (If applicable): ☐ Mother ☐ Father ☐ Active ☐ Inactive ☐ Guard ☐ Reserve ☐ NA	Military Branch: ☐ Army ☐ Air Force ☐ Marines ☐ Navy ☐ Coast Guard

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, 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: _____

_____

_____

Date _____ Signature of Parent or Guardian _____

Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II *REFUSAL TO CONSENT*

I **do not give consent** for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take no action or to: _____

_____

_____

Date _____ Signature of Parent or Guardian _____

Address _____