

EMERGENCY MEDICAL AUTHORIZATION FORM

CONFIDENTIAL INFORMATION
CLINIC USE

INSTRUCTIONS: As mandated by the State a completed form must be on file for each student.
Please print legibly and retain a copy for your records.

Locker No.: _____ Grade: _____ Room No.: _____ Date of Birth: _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ Zip _____

Home Phone w/area code _____

Transportation: Car _____ Walk _____ Extended _____

Please list the names of parents and/or their designees to authorize emergency medical treatment for children who become ill or injured while under school authority. Kindly inform the school office of any changes in regards to this document. In each of the # _____ blanks indicate the order in which you wish calls to be made (#1, #2, etc).

RESIDENTIAL PARENT OR GUARDIAN: (Please include area codes with all numbers.)

Mother's Name _____ Day Phone _____ # _____
First Last

Cell Phone _____ # _____

Father's Name _____ Day Phone _____ # _____
First Last

Cell Phone _____ # _____

Step Mother _____ Day Phone _____ # _____
First Last

Cell Phone _____ # _____

Step Father _____ Day Phone _____ # _____
First Last

Cell Phone _____ # _____

IF PARENT/GUARDIAN CANNOT BE REACHED, LIST DESIGNEES (AUTHORIZED PERSONS):

Address _____ Relationship _____

Day Phone _____ # _____

Zip _____ Cell Phone _____ # _____

Address _____ Relationship _____

Day Phone _____ # _____

Zip _____ Cell Phone _____ # _____

PART I: TO GRANT CONSENT

(please print)

I hereby give consent for the following medical care providers and local hospital to be called.

PHYSICIAN _____ Phone _____
(w/area code)

DENTIST _____ Phone _____
(w/area code)

MEDICAL SPECIALIST _____ Phone _____
(w/area code)

LOCAL HOSPITAL _____ Phone _____
(w/area code)

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 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 to the performance of such surgery.

Listed below are facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____
Address _____
City _____ Zip _____

PART 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 no action or to take the following action:

Date _____ Signature of Parent/Guardian _____
Address _____
City _____ Zip _____