

2016 - 2017

EMERGENCY MEDICAL AUTHORIZATION

#6

Child's Name: \_\_\_\_\_ Class \_\_\_\_\_
Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_
Mothers' Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_
Fathers' Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know. \_\_\_\_\_

Purpose: To enable parents or 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.

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

Doctor \_\_\_\_\_ Daytime Phone: \_\_\_\_\_
Dentist \_\_\_\_\_ Daytime Phone: \_\_\_\_\_
Medical Specialist \_\_\_\_\_ Daytime Phone: \_\_\_\_\_
Local Hospital \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_

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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 action: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_