ROOM ________

GRADE ________

DATE ____________________

2017-2018 EMERGENCY MEDICAL AUTHORIZATION FORM

School ____________________________________ Student Name ____________________________

Student Birthdate __________________________ Address ________________________________

____

Telephone ______________________________

Purpose – to enable parents 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.

Residential parent or Guardian:

Mother's Name ______________________________________ Daytime Phone __________ ________
First Last
Cell Phone ________________________

Mother's Employer ___________________________________ Phone ___________________________

Father's Name _______________________________________ Daytime Phone ____________________
First Last
Cell Phone ________________________

Father's Employer ____________________________________ Phone ___________________________

Other's Name ____ Daytime Phone ____________________

Name of relative or Childcare Provider:

____ Relationship ______________________

Address ____ Daytime Phone ____________________

__________________________________Zip ____________

I give permission for School Personnel to administer Tylenol at school. ______ Yes ______ No

I give permission for School Personnel to administer Tums at school. ______ Yes ______ No

In the Event of an emergency early dismissal my child should:

_____ Ride the bus

_____ Wait to be picked up

PART I OR II MUST BE COMPLETED
(See Reverse Side)

PART I: TO GRANT CONSENT (The separate authorization to Administer Medication or Carry Inhaler form must be completed if applicable.)

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

Physician ______________________________ Phone ______________________________

Dentist ______________________________ Phone ______________________________

Medical Specialist ______________________________ Phone ______________________________

Local Hospital ______________________________ Emergency Room 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 above name doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (1) the transfer of the child to any hospital reasonable 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:

____

____

Date ____________________ Signature of Parent/Guardian ______________________________

Address ______________________________

______________________________ 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 the following action:

____

____

Date ____________________ Signature of Parent/Guardian ______________________________

Address ______________________________

______________________________ Zip __________