Emergency Medical Authorization

______________________________ ______________________________

School Student Name

If we are unable to contact you, please list the name of a friend or neighbor ______________________________ Address

Name______________________________ ______________________________ Phone #

Phone #______________________________

Purpose – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I and Part II must be completed

Part I (to grant consent)

In the event reasonable attempts to contact me at ______________________________ phone #

or______________________________ (other parent) at ______________________________phone #

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 preferred practitioner is not available, by another licensed physician or dentist: and (2) the

transfer of the child to ______________________________ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before the surgery is performed.

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

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______________________ ______________________ ______________________

Date Signature of Parent Address

Please see other side

Do not complete Part II if you completed Part I

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:

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Date	Signature of Parent