

EMERGENCY MEDICAL AUTHORIZATION

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. This information may be shared with the educational team to best meet your child's needs.

Student Name _____ Phone # _____ Bus # _____
 Address _____ School District _____
 _____ School Attending _____
 Address Change Y N Birth Date _____ Sex M F Grade ____ Home Room _____

Residential Parent or Guardian

Mother _____ Day Ph # _____ Cell # _____
 Email _____ Pager # _____

Father _____ Day Ph # _____ Cell # _____
 Email _____ Pager # _____

Other Name _____ Day Ph # _____ Cell # _____

Name of Relative or Childcare Provider _____

Address _____ Phone # _____

Relationship _____

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

Doctor _____ Phone # _____

Dentist _____ Phone # _____

Medical Specialist _____ Phone # _____

Hospital _____ Phone # _____

Below check any current health condition that may require attention during the school day:

- | | |
|---|--|
| <input type="checkbox"/> Allergies (be specific) | <input type="checkbox"/> Concussion/head injury — year _____ |
| <input type="checkbox"/> Foods _____ | <input type="checkbox"/> Physical disability (be specific) _____ |
| <input type="checkbox"/> Medicines _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bee Stings _____ | <input type="checkbox"/> Respiratory (be specific) _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Vision problems (be specific) _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hearing problems <input type="checkbox"/> Hearing aid(s) | <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Heart problems (be specific) _____ | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Behavior/emotional problems _____ |
| <input type="checkbox"/> Surgeries (include year) _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Other (be specific) _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

List all medications and dosages your child receives on a continual basis:

PLEASE COMPLETE PART I OR PART II — NOT BOTH**Part I — TO GRANT CONSENT**

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 the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date _____ Parent or Guardian Signature _____

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: _____

Date _____ Parent or Guardian Signature _____