

# SCHOOL HEALTH SERVICES EMERGENCY MEDICAL AUTHORIZATION

School: \_\_\_\_\_  
Student Name \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address \_\_\_\_\_  
School attended: \_\_\_\_\_ School year: \_\_\_\_\_

**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 or Part II must be completed**

## PART I – TO GRANT REQUEST

In the event reasonable attempts to contact me at \_\_\_\_\_ or \_\_\_\_\_  
at \_\_\_\_\_ have been unsuccessful, I hereby give my consent for 1) the  
administration of any treatment deemed necessary by Dr. \_\_\_\_\_ or  
Dr. \_\_\_\_\_ in the event the designated preferred practitioner is not  
available, by another licensed physician or dentist; and 2) the transfer of the child to  
\_\_\_\_\_ or 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 before 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:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## 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:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date Signature of Parent Address