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 _____
Phone other parent
at _____ have been unsuccessful, I hereby give my consent for 1) the
Phone
administration of any treatment deemed necessary by Dr. _____ or
preferred physician
Dr. _____ in the event the designated preferred practitioner is not
preferred dentist
available, by another licensed physician or dentist; and 2) the transfer of the child to _____ or any hospital reasonably accessible.
preferred hospital

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:

_____

_____

Date **Signature of Parent** **Address**

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**