

DATE _____

ROOM _____
GRADE _____

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 _____
First Last

Daytime Phone _____
Cell Phone _____

Mother's Employer _____

Phone _____

Father's Name _____
First Last

Daytime Phone _____
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

<p>In the Event of an emergency early dismissal my child should:</p> <p>_____ Ride the bus</p> <p>_____ Wait to be picked up</p>
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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 _____