# EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ Grade _____ Telephone _____
Address _____
Social Security Number _____

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 _____ Phone: Work _____ Home _____
Father's Name _____ Phone: Work _____ Home _____
Other's Name _____ Phone: Work _____ Home _____

Name of Relative or Childcare Provider
_____ Relationship _____
Address _____
Daytime Phone _____

**Please list all appropriate medical history of the said child, allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____
_____
_____

PART I OR II MUST BE COMPLETED

Part I: To Grant Consent
I hereby give consent for the following medical care providers and local hospital to be called:
Physician _____ Telephone _____
Dentist _____ Telephone _____
Medical Specialist _____ Telephone _____
Local Hospital _____ Emergency Room Telephone _____

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

This authorizations 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.
Date _____ Signature of Parent/Guardian _____
Complete Address _____

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 _____
Complete Address _____

8/92 REVISED EMERGENCY MEDICAL AUTHORIZATION FORM IS MANDATED BY HOUSE BILL 639