

**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:**

- Allergies (be specific)
  - Foods \_\_\_\_\_
  - Medicines \_\_\_\_\_
  - Bee Stings \_\_\_\_\_
  - Other \_\_\_\_\_
- Asthma
- Cancer
- Diabetes
- Hearing problems  Hearing aid(s) \_\_\_\_\_
- Heart problems (be specific) \_\_\_\_\_
- Surgeries (include year) \_\_\_\_\_
- Concussion/head injury — year \_\_\_\_\_
- Physical disability (be specific) \_\_\_\_\_
- Respiratory (be specific) \_\_\_\_\_
- Seizures \_\_\_\_\_
- Vision problems (be specific) \_\_\_\_\_
  - Glasses  Contacts
- ADD/ADHD
- Behavior/emotional problems \_\_\_\_\_
- Other (be specific) \_\_\_\_\_

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 \_\_\_\_\_