EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents / guardians to authorize emergency treatment for children who become ill or injured while under school authority when parents / guardians cannot be reached. This is an important **precautionary measure** which, it is hoped, will never need to be used.

Instructions: Complete **EITHER** PART I or PART II. **DO NOT** complete both sections. Sign and date where indicated.

To Grant Consent, Complete

PART I

In the event reasonable attempts to contact me or my alternate contact have been unsuccessful, I hereby give my consent for

(1) the administration of any treatment deemed necessary by my preferred Doctor or Dentist, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and

(2) the transfer of the child to my preferred hospital or any reasonably accessible hospital.

	Name	Telephone No.
First Contact		
Alternate Contact		
Preferred Doctor		
Preferred Dentist		
Preferred Hospital		

This authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery, and concurrence is obtained before the surgery is performed.

Listed below are all facts concerning the child's medical history, including allergies, medications being taken and any physical impairments to which a physician should be alerted:

_____

_____

_____

_____

_____ _____

Parent Signature Date

To Refuse Consent, Complete

PART II

I **DO NOT** give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to

_____.

_____ _____

Parent Signature Date