EMERGENCY MEDICAL AUTHORIZATION

Student Name	Address	Phone

School District	School Attended

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.

A. Residential Parental Guardian

Mother's Name	Mother's Daytime Phone No.
Father's Name	Father's Daytime Phone No.
Other Name	Other Daytime Phone No.

B. Name of Relative or Childcare Provider

Name	Relationship
Address	Phone No.

---------- 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:

Doctor's Name	Phone No.
Dentist's Name	Phone No.
Medical Specialist	Phone No.
Local Hospital	Emergency Room Phone No.

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 doctor, or in the event the 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 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

---------- 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 the following action:

_____

Date	Signature of Parent/Guardian	Address