

2017-2018

Purpose: This form is to be completed by the parent/guardian to authorize the provision of emergency treatment for children who become ill or injured while under the school authority, when the parent(s) / guardian(s) cannot be reached.

Student Name: _____ **School:** _____ **Grade:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Telephone: () _____ **Student Date of Birth:** _____

PARENT / GUARDIAN INFORMATION: *(Please Print)*

Emergency Contact #1 **Mother/Guardian:** _____ **Daytime Phone:** _____

Cell: _____ **Email:** _____ **Residential?** · Yes · No

Emergency Contact #2 **Father/Guardian:** _____ **Daytime Phone:** _____

Cell: _____ **Email:** _____ **Residential?** · Yes · No

Emergency Contact #3 **Name:** _____ **Relationship:** _____

Cell: _____ **Email:** _____ **Residential?** · Yes · 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: _____ **Dentist:** _____ **Specialist:** _____

Phone: () _____ **Phone:** () _____ **Phone:** () _____

Local Hospital: _____ **Phone:** () _____

Medical Insurance Company: _____ **Name of Insured:** _____

Facts concerning the child's medical history including allergies: _____

Medications being taken or physical impairments to which a physician should be alerted: _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named medical care providers, or, in the event the above-named medical care providers are 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.

Signature of Parent/Guardian: _____ **Date:** _____

· **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 actions:

ACTION TO BE TAKEN: _____

Signature of Parent/Guardian

Date