(Please print except for signatures) Homeroom #_____ **Grade**_____

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name_____ Parent E-Mail_____

Address_____

Preferred phone number for parent notification system_____

Emergency call order (Please underline cell, work, or home):

	Phone#	Name	Relationship to student
1st:	_____ cell, work, home	_____	_____
2nd:	_____ _____ cell, work, home	_____	_____
3rd:	_____ _____ cell, work, home	_____	_____

Student resides with_____

PART I OR PART II MUST BE COMPLETED

PART I - GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____Phone_____

Dentist_____Phone_____

Med. Specialist_____Phone_____

Local Hospital_____Phone_____

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 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:

_____

_____

Signature of Parent/Guardian_____ **Date**_____

PART II - REFUSE 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:

_____

Signature of Parent/Guardian_____ **Date**_____