EMERGENCY MEDICAL AUTHORIZATION

Student Name _____

Address _____

Telephone _____

NAME: _____ Last _____ First _____ BIRTHDATE: _____

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.

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____(phone number) or _____(other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent or: (1) the administration of any treatment deemed necessary by Dr. _____(physician & phone number) or Dr. _____ (dentist & phone number), 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 _____(hospital) or 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 or Guardian

_____

Address

DO NOT COMPLETE PART II IFYOU 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 no action or to:

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

_____

Address

MU-SSM-12
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