## EMERGENCY MEDICAL AUTHORIZATION

Student Name		Grade	HR Teacher	
Address			Telephone	
Residential Parent or Guardian_				
Mother living with family? Ye	s $\square$ No	Father liv	ing with family?	Yes No
Mother	Daytime PhoneCell			
Father				
Other Name			Phone	Cell
Name of relative or childcare provide			2	Relationship
<del>_</del>				
Home Email Address				
Sibling Information				
Name	Age	School		Grade
Name	Age	School		Grade
Name	Age	School		
Ivanie		0011001		
PURPOSE- to enable parents to au school authority when parents cannot PART I OR PART II MUST BE CO	t be reached. Please	e notify the So	chool with any change	s.
	PART I (	To Grant Co	nsent)	
I hereby give consent for the following	ng medical care pro	viders and loc	cal hospital to be called	d:
Doctor	1	Telep	hone	
Dentist		Telep	hone	
Medical Specialist		Telep	hone	
Local Hospital		Telep	hone	
In the event reasonable attempts to conditions administration of any treatment deem Dr	ned necessay by Dr.  (preferred dentistian or dentist; and (sible.  a sible.  a surgery unless to the surgery, are obatined history including a surgery.	t), or in the ev (2) the transfer the medical op d before the so	vent the disignated prefer of the child to  binions of 2 other licenurgery is preformed.	(preferred doctor) or ferred practitioner is not used physicians or dentists, and any physical impairments to
which a physician of areas.				
•				
(Date) (Signature of	of Parent/Guardian)	ŧ	,	(Address)
DO NOT COMPLETE PART II II	PART II (	Refusal of C	onsent)	
I DO NOT GIVE MY CONSENT for emergency treatment, I wish the school	r emergency medic ool authorities to tal	al treatment o ke <b>no</b> action <b>o</b>	f my child. In the ever r to:	nt of illness or injury requiring
		-		
(Date) (Signature	of Parent/Guardian)			(Address)