EMERGENCY MEDICAL AUTHORIZATION

☐ **High School** ☐ **Middle School** ☐ **Maple Leaf** ☐ **William Foster** ☐ **Elmwood**

Student Name _____ Grade _____ Homeroom Teacher _____
Address _____ Telephone _____

Residential Parent or Guardian
Mother living with family? ☐ Yes ☐ No Father living with family? ☐ Yes ☐ No
Mother _____ Daytime Phone _____ Cell _____
Father _____ Daytime Phone _____ Cell _____
Other Name _____ Daytime Phone _____ Cell _____
Name of relative or childcare provider _____ Telephone _____ Relationship _____
_____ Address _____
Home Email Address _____ Work Email Address _____

Sibling Information
Name _____ Age ____ School _____ Grade _____
Name _____ Age ____ School _____ Grade _____
Name _____ Age ____ School _____ Grade _____

PURPOSE – To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached. Please notify the School with any changes.

PART 1 OR PART 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 _____ Telephone _____
Dentist _____ Telephone _____
Medical Specialist _____ Telephone _____
Local Hospital _____ Telephone _____

In the event reasonable attempts to contact me or the family members listed above, I hereby give my consent for: the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____ (preferred dentist), 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 _____ (preferred hospital) reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is preformed.

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 HAVE COMPLETED PART I

PART II (Refusal of 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/Guardian) (Address)