

# EMERGENCY MEDICAL AUTHORIZATION

**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. This information may be shared with the educational team to best meet your child's needs.

Student Name \_\_\_\_\_ Phone # \_\_\_\_\_ Bus # \_\_\_\_\_  
 Address \_\_\_\_\_ School District \_\_\_\_\_  
 \_\_\_\_\_ School Attending \_\_\_\_\_  
 Address Change Y N Birth Date \_\_\_\_\_ Sex M F Grade \_\_\_\_\_ Home Room \_\_\_\_\_

**Residential Parent or Guardian** \*\*Email \_\_\_\_\_

Mother \_\_\_\_\_ Day Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Father \_\_\_\_\_ Day Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
 Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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

Doctor \_\_\_\_\_ Phone # \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone # \_\_\_\_\_  
 Medical Specialist \_\_\_\_\_ Phone # \_\_\_\_\_  
 Hospital \_\_\_\_\_ Phone # \_\_\_\_\_

**Check below any CURRENT health condition that may require attention during the school day:**

- Allergies (be specific)
  - Foods \_\_\_\_\_ EpiPen \_\_\_ Yes \_\_\_ No
  - Medicines \_\_\_\_\_
  - Bee Stings \_\_\_\_\_ EpiPen \_\_\_ Yes \_\_\_ No
  - Other \_\_\_\_\_
- Asthma Uses emergency inhaler \_\_\_ Yes \_\_\_ No  
Inhaler will be at school \_\_\_ Yes \_\_\_ No
- Cancer
- Diabetes
- Seizures
- Heart problems (be specific) \_\_\_\_\_
- Physical disability (be specific) \_\_\_\_\_
- List all medications and dosages your child receives on a continual basis: \_\_\_\_\_
- Other health conditions (be specific) \_\_\_\_\_
- Previous surgeries (be specific) \_\_\_\_\_
- Previous concussion/head injury-year \_\_\_\_\_
- Hearing problems Has hearing aids \_\_\_ Yes \_\_\_ No
- Vision problems (be specific) \_\_\_\_\_
- Wears:  Glasses  Contacts \_\_\_\_\_
- ADD/ADHD
- Behavior/emotional problems \_\_\_\_\_
- Bleeding Disorder
- NO CURRENT HEALTH CONDITIONS**

## PLEASE COMPLETE PART I OR PART II — NOT BOTH

### Part I — TO GRANT CONSENT

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 designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_

### 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 \_\_\_\_\_ Parent or Guardian REFUSAL Signature \_\_\_\_\_