

Teacher Name _____ Grade _____

EMERGENCY MEDICAL AUTHORIZATION 20 -20

Student Name _____

Address _____

Telephone _____ School Attending _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority when parents or guardians cannot be reached.

PART I OR PART II MUST BE COMPLETED

Part I - To Grant Consent

In the event reasonable attempts to contact me at _____ (phone #) or _____ (pager or cell phone) or _____ (spouse/guardian) at _____ (phone #) or _____ (pager or cell phone) have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician), 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) 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, medication being taken, and any physical impairments to which a physician should be alerted: _____

Date Signature of Parent or **Legal** Guardian

DO NOT COMPLETE PART II IF YOU 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 **Legal** Guardian

Copies of this form are sent to the Beavercreek/Sugarcreek/Fairborn Transportation Department and the St. Luke School Extension Program (if applicable).