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.

Person(s) who may be notified and to whom your child/children may be released if the school cannot reach you:

1) ____ **Relationship** _______________ **Phone**______________________

2) ____ **Relationship** _______________ **Phone**______________________

To Grant Consent:

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the Physician listed below, or in the event that the designated preferred practitioner is not available, another licensed physician or dentist may administer treatment; (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless a concurring medical opinion of two other licensed physicians or dentists deems it a necessity for such surgery, provided the opinion is obtained prior to the performance of such surgery.

Physician Name:____ **Phone:** _______________________________

To Refuse 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, but instead to:

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Medical Authorization

Under what circumstances should we call you? (Parents will automatically be called if a child suffers a head injury or has a fever.)

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The following medications may be given: (Please check the boxes Yes or No)

☐Y ☐N First Aid Cream ☐Y ☐N Cough Drops ☐Y ☐N Pepto-Bismol
☐Y ☐N Benadryl ☐Y ☐N Cough Syrup ☐Y ☐N Ibuprofen
☐Y ☐N Sudafed ☐Y ☐N Antacid ☐Y ☐N Tylenol

Any known medical conditions (such as allergies or diabetes):

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Any other pertinent medical information: ____________________________________

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Parent's or Guardian's Signature: ___________________________________ **Date** _____________________