

Student's Name: _____ Grade: _____ DOB: _____

Address: _____ Telephone #: _____ or _____

Please list all names and phone number of people we can call if your child becomes ill and needs to go home.

Mother's name: _____ Daytime #: _____ Cellular #: _____

Father's name: _____ Daytime #: _____ Cellular #: _____

Name of relative/childcare provider: _____ Relationship: _____ Address: _____

Telephone #: _____ Cellular #: _____ Other #: _____

Other person/relationship: _____ Daytime #: _____ Cellular #: _____

Other person/relationship: _____ Daytime #: _____ Cellular #: _____

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. PART I 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 at _____ (phone #) or _____ (other parent) at _____ (phone #) have been unsuccessful, I hereby give me consent for: (1) 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) or any hospital reasonably accessible.

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

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: _____ 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: _____ Address: _____