

# EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION FORM

School: \_\_\_\_\_ Student Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of *Custodial* Parent(s) or Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Cell Work

Name of *Non-Custodial* Parent(s) (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Cell Work

## Emergency Calling Order

Please list, in order of priority, whom to call in case of an emergency that involves your child. Be sure to include both custodial and non-custodial parents in this list as appropriate / desired. Unless you indicate otherwise, the individuals listed below are also authorized to pick-up or sign-out your child from school, even for non-emergencies.

	NAME	RELATIONSHIP	PHONE
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

## COMPLETE PART I OR II

### PART I: TO GRANT CONSENT

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

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

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 above-named doctors, 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 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, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

### 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, please take the following actions:

\_\_\_\_\_  
\_\_\_\_\_

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