

EMERGENCY MEDICAL AUTHORIZATION
TRI-VALLEY LOCAL SCHOOLS

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Student Name _____
Street Address _____
P.O. Box _____ City _____
Telephone _____
E-Mail (1) _____
E-Mail (2) _____
Grade _____ Bus Number _____
Birthdate _____ Homeroom _____

In case of emergency, please contact:

Mother's Name _____ Home Phone _____ Cell Phone _____
Place of Work _____ Work Phone _____
Father's Name _____ Home Phone _____ Cell Phone _____
Place of Work _____ Work Phone _____

Other emergency contacts:

1. _____ Phone _____ / _____ Relationship _____
2. _____ Phone _____ / _____ Relationship _____
3. _____ Phone _____ / _____ Relationship _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: _____ Date of last tetanus shot: _____

Medication being taken: _____ Physical impairments: _____

Other medical information: _____

Other pertinent information for school (custody, etc.): **PLEASE LIST SIBLING INFORMATION ON THE BACK OF THIS FORM.**

PART I: TO GRANT CONSENT

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

Physician _____ Phone _____
Dentist _____ 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.

_____ Date _____ Signature of Parent/Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency 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

