EMERGENCY MEDICAL AUTHORIZATION CARD

(PLEASE PRINT)

Child's Name_____
(Last) (First) (Middle)

School:_____Homeroom Teacher:_____

Home Address:_____ Home phone:_____

Birth Date____/____/____ Email:_____ Cell phone:_____
Month Day Year

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

ONLY LIST PERSON(S) WHO ARE ALLOWED TO PICK UP YOUR CHILD

II. Father_____
(Name) (Where Employed) (Telephone)

Mother _____
(Name) (Where Employed) (Telephone)

Guardian_____
(Name) (Where Employed) (Telephone)

III. LIST ANY PERSON(S) WHO HAS TRANSPORTATION & ALSO MAY ASSUME RESPONSIBILITY FOR YOUR CHILD IF YOU CANNOT BE REACHED:

_____
(Name) (Address) (Relationship) (Telephone)

_____
(Name) (Address) (Relationship) (Telephone)

IV. LIST YOUR PREFERENCE:

Physician _____
(Name) (Office Address) (Telephone)

Dentist _____
(Name) (Office Address) (Telephone)

Hospital _____
(Name) (Telephone)

V. In case of emergency, illness, or accident to your child, the school is authorized to proceed as indicated below. List order of ACTION DESIRED (1-2-3-4-5-6).

( ) Contact Father
( ) Contact Mother
( ) Contact Physician
( ) Contact Guardian
( ) Take my child to Hospital Emergency Room
( ) Other procedure desired_____

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.

VI. If your child has any known physical condition which could require specific emergency procedure by school personnel including severe allergies, medication being taken, diabetes, seizures, heart condition, asthma, physical impairments, etc., please list condition and indicate below procedure you want school personnel to follow:_____

Name of Insurance Co._____

SIGN TO CONSENT _____
Date Parent or Guardian Signature

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 the following action:_____

Date_____ Signature of Parent or Guardian_____

Address_____