STRUTHERS CITY SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

Student Name____ Grade________ Teacher/Homeroom________________

Address____ Phone____________________________

Parent E-Mail Address ____

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.

Mother's Name ____ Daytime phone # ___________________________

Father's Name ____ Daytime phone # ___________________________

Other's Name ____Daytime phone # ___________________________

Name of relative or child care provider ____________________________________Relationship ______________________

Address ____ Daytime phone # ___________________________

PART I OR 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:

Physician ____ Phone #_________________________________

Dentist ____ Phone #_________________________________

Medical Specialist ____ Phone #_________________________________

Hospital ____ ER 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 of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications taken, and any physical impairment to which a physician or school personnel should be alerted. ____

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Signature of Parent/Guardian____Date __________________

Address ____

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: ________________________________

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Signature of Parent/Guardian____Date __________________

Address ____