Emergency Medical Authorization

Once completed you can save then upload your document through the Digital Academy app with your smart phone or return it to the school office.

School _____

Student Name_____

Address _____

Telephone_____

Residential Parent or Guardian

Mother Living with Family? ☐ Yes ☐ No

Father Living with Family? ☐ Yes ☐ No

Mother_____ Daytime Telephone_____

Father_____ Daytime Telephone_____

Other Name_____ Daytime Telephone_____

Relative or Childcare Provider_____ Telephone_____

Address_____ Relationship_____

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 1 (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 _____(tel #) or _____(other parent) at _____(tel #) have been unsuccessful, I hereby give my 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.

The authorization does not cover major surgery unless the medical opinions of 2 other license physicians or dentist, 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 1

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_____