

EMERGENCY MEDICAL AUTHORIZATION FORM

(Required per HB 639)

Student Name _____ School _____

Address _____
Street/P.O. Box _____ City _____ Zip _____

Home Phone () _____ DOB ____/____/____ Grade _____ Teacher/Team _____

PARENT CONTACT INFORMATION

MOTHER/GUARDIAN:

Name _____

Address _____

City/State/Zip _____

Email address _____

Home PH: _____ Cell PH: _____

Work Place: _____ WK PH: _____

FATHER/GUARDIAN:

Name _____

Address _____

City/State/Zip _____

Email address _____

Home PH: _____ Cell PH: _____

Work Place: _____ WK PH: _____

Is there a legal custody order that applies to this child? Yes _____ No _____ Copy of custody papers must be on file in office.

If yes, please explain: _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority. In the event that you can not be reached, please list (3) people to whom you give permission to pick up your child from school in case of **illness or injury**. If we are unable to reach you, we will contact the people listed below in the order they are listed.

	Name	Home #	Cell #	Work #	Relationship to Child
1.	_____ () _____	_____ () _____	_____ () _____	_____	_____
2.	_____ () _____	_____ () _____	_____ () _____	_____	_____
3.	_____ () _____	_____ () _____	_____ () _____	_____	_____

Facts concerning the child's medical history including allergies, medications being taken or current health concerns:

May this health information be shared with appropriate school personnel such as your child's teacher(s)? Yes _____ No _____

Date _____ Signature of Parent/Guardian _____

COMPLETE EITHER PART I OR PART II

PART I – CONSENT FOR TREATMENT

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 the named doctor, or in the event the designated practitioner is unavailable, 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 to the performance of such surgery.

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

Doctor _____ Phone () _____

Dentist _____ Phone () _____

Hospital _____

Date _____

Signature of Parent/Guardian

PART II – REFUSAL TO GRANT CONSENT FOR TREATMENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take the following action:

Date _____

Signature of Parent/Guardian
Sign only if refusal to consent