



EMERGENCY MEDICAL AUTHORIZATION (REQUIRED PER HB 639)

Student Name _____ Date of Birth _____
 Teacher _____ AM __ PM __ Telephone _____
 Address _____ Grade _____

PURPOSE: To enable parent/guardian to authorize emergency treatment for students who become ill or injured while under school authority. By listing additional emergency contacts, you are giving permission for that contact to pick up your student from school in the event of illness or injury should a parent/guardian be unavailable. *I understand medical information provided on this form will be shared with school personnel who interact with my student to ensure his/her safety at school unless I note otherwise.*

EMERGENCY CONTACT NUMBERS (MINIMUM 2 CONTACTS)

	Name	Home #	Cell #	Work #	Relationship to Student
1.					
2.					
3.					
4.					

IMPORTANT MEDICAL INFORMATION

PLEASE LIST ANY pertinent medical history or information about existing conditions that may affect your student at school including allergies, medications, current medical conditions, and any physical impairments to which the school should be alerted:

PLEASE SIGN EITHER PART 1 TO GRANT CONSENT OR PART II TO REFUSE CONSENT BELOW:

PART I - TO GRANT CONSENT

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

Doctor: Phone:	Dentist: Phone:	Preferred Local Hospital: Phone:
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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 doctor, or in the event the designated practitioner is unavailable, by another licensed physician or dentist; and (2) the transfer of the student 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.

PARENT/GUARDIAN SIGNATURE: _____ DATE _____

PART II - REFUSAL TO GRANT CONSENT

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

PARENT/GUARDIAN SIGNATURE: _____ DATE _____