

NEED 2 COPIES - NEW ALBANY-PLAIN LOCAL SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

(Please press firmly)

Student Name _____ Grade _____
Address _____ Date of Birth _____
_____ Zip _____
Home Phone _____ Cell / Pager _____
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.

Residential Parent or Guardian

Mother's Name _____ Day Phone (_____) _____
Father's Name _____ Day Phone (_____) _____
Other's Name _____ Day Phone (_____) _____
Name of Relative or Childcare Provider _____ Relationship _____
Address _____ Day Phone(_____) _____
_____ Zip _____

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 _____
Local Hospital _____ 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 for such surgery, are obtained prior to the performance of such surgery.

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/GUARDIAN _____

ADDRESS _____ CITY _____ ZIP _____

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/GUARDIAN _____

ADDRESS _____ CITY _____ ZIP _____