Emergency Medical Authorization Form (Required per HB 639)

Student Name:	**Date of Birth:**
Address:	**Telephone:**

PURPOSE: *To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians cannot be reached*

Emergency Contact Numbers (Minimum of 2 Contacts)

Name	Home/Cell #	Relationship to student

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 I 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:

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:_____ 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(write in the space given below):

PARENT/GUARDIAN:_____ DATE:_____

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