TRI-COUNTY NORTH LOCAL SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

STUDENT: ____________________

ADDRESS: ____________________

TELEPHONE: ____________________

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: ____________________ Daytime Phone: ____________________

Father's Name: ____________________ Daytime Phone: ____________________

Other's Name: ____________________ Daytime Phone: ____________________

NAME OF RELATIVE OR CHILD CARE PROVIDER:

____________________ Relationship: ____________________

Address: ____________________ Phone: ____________________

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PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

Doctor: ____________________ Phone: ____________________

Dentist: ____________________ Phone: ____________________

Medical Specialist: ____________________ Phone: ____________________

Local Hospital: ____________________ Emergency Room Phone: ____________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my 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 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:

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Date: ____________________ Signature of Parent/Guardian: ____________________

Address: ____________________

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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 authority to take the following action:

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Date: ____________________ Signature of Parent/Guardian: ____________________

Address: ____________________