# EMERGENCY MEDICAL AUTHORIZATION FORM

(Required per HB 639)

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.

**Please check here if any of the directory and/or contact information has changed from last year. _____**

Student Name _____School _____

Address_____
Street/P.O. Box City Zip

Home Phone ( ) _____ DOB ___ /___/___ Grade _____ Teacher/Team_____

## EMERGENCY CONTACT INFORMATION

Mother: _____Home Phone_____ Cell_____Work Phone_____

Father: _____Home Phone_____ Cell_____Work Phone_____

Guardian: _____ Home Phone_____ Cell_____ Work Phone_____

Parent email address: _____
Is there a legal custody order that applies to this child? Yes_____ No_____
If yes, please explain: _____

Parents/guardians listed above will be contacted first. If unable to be reached, please **list 3 other local emergency contacts who may** be contacted and permitted to pick up your child from school in case of **illness or injury**.

| Name | Daytime Phone / Cell Phone | Relationship to Child |
|---|---|---|
| 1._____ | _____ _____ | _____ |
| 2. _____ | _____ _____ | _____ |
| 3._____ | _____ _____ | _____ |

## CONSENT

In the event that 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/dentist, or, in the event the designated 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.

I hereby give consent for the following medical care providers and local hospital to be called:
Doctor: _____Phone: _____
Dentist: _____Phone: _____
Preferred Hospital: _____Phone: _____
Medical Insurance Provider:_____Policy #:_____
**Child's medical history including allergies, medications being taken, and specific health concerns:**

_____
_____
_____
_____

May this health information be shared with appropriate personnel such as your child's teacher(s)? Yes_____No_____
Parent/Guardian Signature _____Date:_____

## REFUSAL TO CONSENT- Complete only if action described above is refused

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 actions:

_____

Parent/Guardian Signature:_____Date: _____