

EMERGENCY MEDICAL AUTHORIZATION

METRO-EAST LUTHERAN HIGH SCHOOL
6305 Center Grove Road
Edwardsville, IL 62025

Student's Name _____

Address _____

City _____

(618) 656-0043

Telephone _____

Place of Birth _____

Date of Birth _____

Purpose - to enable parents and guardians to authorize the provision of emergency for children who become ill while under school authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ phone number
or _____ (other parent or guardian
and phone number) have been unsuccessful, I hereby give my consent for:
(1) the administration of any treatment deemed necessary by Dr. _____
(preferred physician) or Dr. _____
(preferred dentist), or, in the event the designated preferred practitioner is
not available, by another license physician or dentist; and (2) the transfer of
the child to _____ (preferred hospital) or 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 con-
cerning the child's medical history including allergies, medications taken, and
any physical impairments to which a physician should be alerted:

_____ Date

_____ Parent or Guardian's Signature

_____ Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to:

_____ Date

_____ Signature of Parent or Guardian

Please attach your insurance information
and/or a copy of your insurance card