Emergency Medical Authorization

Student's Name ____

Address (street/city/state) ________________________________

Phone ______________________ Date of Birth ________________

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, especially when parents and guardians cannot be contacted.

Parent/Guardian name ___________________________________ Phone #1_______________ Phone #2_______________

Parent/Guardian name ___________________________________ Phone #1_______________ Phone #2_______________

Alternative emergency contacts *: (Local people to contact if parents cannot be reached; and have your permission to make medical decisions for your child.)*

Name____ Phone_______________ Relationship____________________

Name____ Phone_______________ Relationship____________________

Part I or II MUST be completed - *Please be sure to check "To Grant Consent" or "Refusal to Consent" then sign at the bottom of the page.*

❑ Part I—To Grant Consent

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary.

Physician ____ Phone__________________________________

Dentist____ Phone__________________________________

Hospital____ Phone__________________________________

Student Medical Insurance____ Plan/Group/I.D. Number______________________

** Please include a copy of your insurance card or complete insurance information*

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transportation and medical care of my child to any appropriate medical care provider, hospital, or medical facility. I authorize MELHS personnel to make necessary decisions and take appropriate actions (including the provision of first aid and CPR) in emergency situations on behalf of my student. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted: ____

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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 authorities to take the following action**:** ____

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Signature of Parent/Guardian ____ Date __________________

I give MELHS permission to give my child ______ Acetaminophen, _____ Ibuprofen, and _____ cough drops if requested during the school day. (Please initial if you approve)