EMERGENCY MEDICAL AUTHORIZATION

_____
Please Print Legal Name Last First Middle Initial

_____ _____ _____
Address City Zip Code+4

_____ _____ _____ ☐ Male ☐ Female
Home Telephone Cell Phone Date of Birth

#1_____ _____
Emergency contact person Relationship Phone

#2_____ _____
Emergency contact person other than parent Relationship Phone

_____ _____
Physicians's Name Phone

☐ Medical issues are:_____

☐ No medical issues.

PART I OR II MUST BE COMPLETED (All blanks must be completed and card must be signed)

PART I – TO GRANT CONSENT

If unresponsive, I hereby give my consent for (1) the administration of any treatment deemed necessary by:

Dr._____ _____ Dr._____ _____
(Preferred Physician) Phone (Preferred Dentist) Phone

In the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) transfer to

_____, or any hospital reasonably accessible.
(Preferred Hospital)
This authorization does not cover major surgery unless medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

_____ _____
Signature Date

PART II – REFUSAL TO CONSENT

I DO NOT give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action, OR

to:_____

_____ _____
Signature Date