Student Medical Emergency Authorization

Please complete one form per student.

Form must be received by Friday, August 16, 2019.
****Access to Digital Academy will be blocked until form is received.***

Student's Name & Homeroom**:** _____

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 Full Name	Daytime Phone Number
Home Phone Number	Cell Phone Number
Father's Full Name	Daytime Phone Number
Home Phone Number	Cell Phone Number

Name of Relative or Childcare Provider:

Full Name	Relationship
Address	Daytime Phone Number

See Reverse Side
PART I OR II MUST BE COMPLETED.

PART I: TO GRANT CONSENT:
I hereby give consent for the following medical care providers and local hospital **to be called:**

Physician & Phone Number: _____

Medical Specialist & Phone Number: _____

Preferred Hospital: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1. The administration or any treatment deemed necessary by above-names doctors, or, in the event the designated preferred practitioner is not available, by another licensed or dentist; and
2. The transfer of the child to any hospital reasonably accessible.
   In an event of an emergency, I give my consent to have my child's medical history, including allergies, medications being taken, and any physical impairments, released to emergency, safety and/or law enforcement officials.

This authorization does not cover major surgery unless the medical opinions or two other licensed physicians or dentists, concurring in the necessity for such 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 and/or emergency, safety or law enforcement official should be alerted:

_____

_____

_____

_____

_____

Date Signature of Parent/Guardian

_____

Address

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.

_____

_____

_____

Date Signature of Parent/Guardian

_____

Address