



Emergency Medical Authorization 21-22

Student's Legal Name		Date of Birth	
Homeroom Teacher		Grade	

Purpose: To enable parents/guardians to authorize provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

ALL SECTIONS MUST BE COMPLETED

In the event reasonable attempts to contact Primary Family Contact & Emergency Contacts have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Doctor or Dentist listed:

Preferred Physician		Phone Number	
Preferred Dentist		Phone Number	

In the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

The 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.

Please list any facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Signature of Parent/Guardian:		Date	
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