EMERGENCY MEDICAL AUTHORIZATION

Ayersville School District

Student Name _____ Telephone _____

Address _____ Bus # _____

_____

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.

Part I or II must be completed

Part I to Grant Consent

Residential Parent or Guardian

Mother _____ Daytime phone _____

Father _____ Daytime phone _____

Other name _____ Daytime phone _____

Relative or childcare provider _____

Relationship _____ Phone _____

Address _____

In the event reasonable attempts to contact me or one of the other persons listed above have been unsuccessful, I hereby give my consent for:

1) The administration of any treatment deemed necessary by:
   Dr. _____ (preferred physician)
   Dr. _____ (preferred dentist)
   Dr. _____ (preferred medical specialist)
   Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and
2) The transfer of the child to: _____ Phone _____
   (Preferred hospital)

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.

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

_____

_____ _____

Date Parent/Guardian Signature

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 Parent/Guardian Signature