ALEXANDER JUNIOR HIGH SCHOOL
ALEXANDER LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

Student Name:_____School:_____
First Middle Last

Address:_____Date of Birth:_____

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

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at:

Home Number:_____ Father: Work Number:_____Cell Number:_____

Mother: Work Number:_____Cell Number:_____

have been unsuccessful I herby give my consent for the (1) administration of any treatment deemed necessary by:

Preferred Doctor:_____, Preferred Dentist:_____

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

Preferred Hospital:_____, or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained **BEFORE** the surgery **IS PERFORMED.**

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

OTHER EMERGENCY NUMBERS: _____ _____
(Number) (Name and relationship to student)

_____ _____
(Number) (Name and relationship to student)

_____ _____
(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)

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