Salem City Schools

EMERGENCY MEDICAL AUTHORIZATION

5/11

________________________________ ________________________________
Students Name School Attending

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 can not be reached.

Residential parent or Guardian:

Father ______________________ Daytime Phone ____________Cell______________

Place of Employment______________________ Business Phone________________

Mother ______________________ Daytime Phone ____________Cell______________

Place of Employment______________________ Business Phone________________

Additional Emergency Contact ____________________Daytime Phone ________________

Name of Relative or Childcare Provider ______________________________

Address: ____________________ Phone______________Relationship ________________

PART I OR PART II MUST BE COMPLETED
PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me by telephone have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ____________ (preferred **physician)** Phone__________ or Dr. ____________Phone__________(preferred **dentist**), 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 ________________(preferred **hospital**) or any hospital reasonably accessible. IF OTHER THAN SALEM COMMUNITY HOSPITAL..... STUDENTS WILL BE TRANSPORTED TO SAID HOSPITAL BY AVAILABLE (LOCAL) AMBULANCE.
This 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 the child's allergies and health conditions (indicate if life threatening):

1.______________________ 2.______________________ 3.______________________

Medications being taken ____
Medical Specialist (if any) ____

I/we hereby grant our permission to share all pertinent medical information listed in this form with necessary school and emergency personnel.

____________ ________________________________ ________________________________
Date Signature of Parent or Guardian Address

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 for my child. In the event if illness requiring emergency treatment. I wish the school authorities to take no action or to:

____

____________ ________________________________ ________________________________
Date Signature of Parent or Guardian Address