SOUTHWEST LOCAL SCHOOL DISTRICT – EMERGENCY MEDICAL AUTHORIZATION

Student's Name	Date of Birth	School Student Attends
Student's Street Address	City	Telephone

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 Name	Mother's Daytime Phone Number
Father's Name	Father's Daytime Phone Number

Name of Relative or Childcare Provider

Name	Relationship	Daytime Phone Number
Street Address	City	Zip Code

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PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor/Specialist Name	Phone Number
Dentist Name	Phone Number
Local Hospital	Emergency Room Phone Number

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 any hospital reasonably accessible.

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.

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

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_______________________________ Date __________ Signature of Parent or Guardian

PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I)

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:

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_______________________________ Date __________ Signature of Parent or Guardian