
Emergency Medical Authorization Form:

Part I: To Grant Consent

Child's Last Name: _____ Child's First Name: _____

Child's Last Name: _____ Child's First Name: _____

Child's Last Name: _____ Child's First Name: _____

Family Name: _____ Home Phone: _____

Street Address: _____ City: _____ Zip: _____

Mother's Name: _____ Cell/pager #: _____

Business Name/Address: _____ Business #: _____

Father's Name: _____ Cell/pager #: _____

Business Name/Address: _____ Business #: _____

Contact in case you cannot be reached: These individuals should be able to pick up your child in the event of illness/other emergency/early dismissal. These people should be aware that they are on this list and have your permission to take your child(ren) home.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Purpose: To enable parents to authorize the provision of emergency treatment for children who become ill or injured under program authority, when parents or guardians 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 _____(phone) or _____(other parent or guardian) at _____(phone) have been unsuccessful, I hereby give my consent for:

1) the administration of any treatment deemed necessary by Dr. _____(preferred physician) at _____(phone) or, Dr. _____(preferred dentist) at _____(phone) 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. 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 before surgery is performed.

Date _____ Parent or Guardian Signature _____

Emergency Medical Authorization Form:

Part II: To Refuse Consent

Child's Last Name: _____ Child's First Name: _____

Child's Last Name: _____ Child's First Name: _____

Child's Last Name: _____ Child's First Name: _____

Family Name: _____ Home Phone: _____

Street Address: _____ City: _____ Zip: _____

Mother's Name: _____ Cell/pager #: _____

Business Name/Address: _____ Business #: _____

Father's Name: _____ Cell/pager #: _____

Business Name/Address: _____ Business #: _____

Contact in case you cannot be reached: These individuals should be able to pick up your child in the event of illness/other emergency/early dismissal. These people should be aware that they are on this list and have your permission to take your child(ren) home.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Part II: 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 program authorities to take no action:

Date

Parent or Guardian Signature