

Centerburg Local Schools - EMERGENCY MEDICAL AUTHORIZATION

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_ 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: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Name of Relative or Childcare Provider: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Local Hospital: \_\_\_\_\_ Emergency Room Phone: \_\_\_\_\_

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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. I hereby authorize Centerburg's sports medicine provider to administer any treatment he/she deems necessary. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_ Yes \_\_\_\_\_ No

I hereby grant permission for \_\_\_\_\_ (number of tablets) pain relievers (i.e. Tylenol, ibuprofen, acetaminophen) to be administered on an as needed basis without contacting me each occurrence.

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 the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_

Supplemental Information:

Student's Birthdate: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher/Homeroom: \_\_\_\_\_  
Date of Last Tetanus: \_\_\_\_\_  
Student resides with (circle all that apply) Mother Father Stepparent Guardian  
Other: \_\_\_\_\_

Additional contact information for those who have authority to make decisions in an emergency situation involving this student.

Mother: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
Father: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
Stepparent: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
Guardian: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
Alternate: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
(relative, child care provider)