

# MADEIRA CITY SCHOOLS

## EMERGENCY MEDICAL AUTHORIZATION

STUDENT'S LAST NAME	MIDDLE INITIAL	FIRST NAME	SCHOOL:	GRADE:	DATE OF BIRTH:
ADDRESS:		TELEPHONE NO.:	CITY/STATE:		ZIP:

**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. Also, to provide emergency contact information in the event parents cannot be reached.

**A. RESIDENTIAL PARENT OR GUARDIAN**

MOTHER'S NAME & ADDRESS:	MOTHER'S DAYTIME PHONE NO.:
MOTHER'S E-MAIL:	MOTHER'S CELL PHONE NO.:
FATHER'S NAME & ADDRESS:	FATHER'S DAYTIME PHONE NO.:
FATHER'S E-MAIL:	FATHER'S CELL PHONE NO.:
OTHER NAME:	OTHER DAYTIME PHONE NO.:

**B. NAME OF RELATIVES, CHILD CARE PROVIDER OR EMERGENCY CONTACTS (PLEASE LIST THE NAME OF TWO CONTACT PERSONS):**

NAME:	RELATIONSHIP:	PHONE NO.:	CELL PHONE NO.:
ADDRESS:		CITY/STATE:	ZIP:
NAME:	RELATIONSHIP:	PHONE NO.:	CELL PHONE NO.:
ADDRESS:		CITY/STATE:	ZIP:

**PART I OR PART 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'S NAME:	PHONE NO.:
DENTIST'S NAME:	PHONE NO.:
MEDICAL SPECIALIST:	PHONE NO.:
LOCAL HOSPITAL:	EMERGENCY ROOM PHONE NO.:

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 impairments to which a physician should be alerted:*

DATE:	SIGNATURE OF PARENT/GUARDIAN:
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ADDRESS:	CITY/STATE:	ZIP:
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**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 the following action:

DATE:	SIGNATURE OF PARENT/GUARDIAN:
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ADDRESS:	CITY/STATE:	ZIP:
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