Madeira Preschool
EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parent and legal custodians to authorize the provision for emergency treatment for children who become ill or injured while under school authority when parents or legal custodians cannot be reached.

Student Name	Phone
Street Address	City State Zip

A. RESIDENTIAL INFORMATION – PARENT/CUSTODIAN

Mother's Name		Daytime Phone
Father's Name		Daytime Phone
Other	Relationship	Daytime Phone

B. NAME OF RELATIVE OR CHILD CARE PROVIDER TO CONTACT IN CASE OF EMERGENCY

Name	Relationship
Street Address	Daytime Phone

C. PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT
I hereby grant consent to the following medical care providers and local hospital to be contacted

Name of Physician	Telephone
Name of Dentist	Telephone
Other Medical Specialist	Telephone
Hospital	Telephone

In the event reasonable attempts to contact me have been unsuccessful, I hereby grant consent for (1) the administration of any treatment deemed necessary by the above named health care providers, or in the event the designated provider is not available by another licensed provider, and (2) the transfer of the child to any hospital reasonable accessible.

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

Signature of Parent or Custodian	Date

PART II – DO NOT COMPLET PART II IF YOU COMPLETED PART I
I do not grant consent for emergency medical treatment of my child. In the event of illness or injury that requires emergency treatment, I wish the school authorities to take the following action:

Signature of Parent or Custodian	Date