INDIAN CREEK SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION FORM

S T U D E N T

School _____ Student Name _____ Grade_____

Teacher_____ Date of Birth_____ Telephone_____

Address_____ Zip_____

Student Lives with:_____

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 (___) _____
First Last

Father's Name _____ Daytime Phone (___) _____
First Last

Other's Name _____ Daytime Phone (___) _____
First Last

Parent/Guardian E-mail address:_____

Name of Relative or Child Care Provider

_____ Relationship _____

Address_____ Daytime Phone (___) _____

Full name(s) of siblings attending IC School District:

Last Name	**First Name**	**Grade**	**Building**	**Teacher**

SEE REVERSE SIDE

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:

Physician _____ 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 the following:

(1) The administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist;

(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 _____

Address _____ Zip _____

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, I wish the school authorities to take the following action:

_____

_____

Date _____ Signature of Parent / Guardian _____

Address _____ Zip _____