

EMERGENCY MEDICAL AUTHORIZATION

LISBON EXEMPTED SCHOOL DISTRICT

DAVID ANDERSON JR/SR HIGH SCHOOL

M F

Grade _____

Student's Name _____

Sex _____

Birth Date _____

MCKINLEY ELEMENTARY SCHOOL

Address _____

Grade _____ Teacher _____

City/State/Zip _____

CHECK IF DIFFERENT ADDRESS FROM LAST YEAR.

Please notify the school of any change in address or phone numbers during the year!

PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT AND TRANSPORTATION OF STUDENTS WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHEN PARENTS OR GUARDIANS CANNOT BE REACHED.

PART I OR II MUST BE COMPLETED

PART I - GRANT CONSENT

In the event the designated preferred practitioner is not available then treatment by another licensed physician or dentist is granted. In the event that the preferred hospital is not accessible then the nearest accessible hospital is preferred. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent or Guardian _____

Address _____

Date _____

In the event reasonable attempts to contact me/us:

Mother's Name or Legal Guardian _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Father's Name or Legal Guardian _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Name of closest relative & relationship _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Name of friend/neighbor _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

IF ALL THESE ATTEMPTS HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY:

Preferred Doctor _____

Phone _____

Preferred Dentist _____

Phone _____

Preferred Hospital _____

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

PART II - REFUSAL TO CONSENT

Signature of Parent or Guardian _____

Address _____

Date _____

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 no action or to: