



# Emergency Medical Authorization

Show, Nurture, Teach, Empower

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Known Allergies \_\_\_\_\_

Medical Conditions & Medications \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### AUTHORIZATION FOR CONSENT TO TREAT

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

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 emergency transfer (EMS) 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.

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

**Over-the-Counter Medication is permitted with parent permission (please sign to permit or decline):**

\_\_\_\_\_ I authorize permission for the above named student to receive over-the-counter medication if needed and as directed on the packet label. A courtesy phone call will be given before administration. Please do NOT give \_\_\_\_\_ weight \_\_\_\_\_

\_\_\_\_\_ I DECLINE, please do NOT give this student ANY over-the-counter medication.

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