Emergency Medical Permit Form

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment of children who become ILL or INJURED while under school authority, when parents or guardians cannot be reached.

Student Name:_____ Grade:_____

Grant Consent:

In the event reasonable attempts to contact me at telephone number:_____ or _____ or (other parent/guardian) at telephone number:_____ have been unsuccessful, I hereby give my consent for:

(1) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr._____ (preferred dentist), 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 _____ (preferred hospital) or any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of tow other licensed physicians or dentist, 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 impairment to which a physician should be alerted.

_____

_____

_____

Date:_____ Signature of Parent/Guardian:_____

Address:_____

Refusal of Consent:

I do not give my consent for emergency medical treatment of my child. In the event of illness of injury requiring emergency treatment, I wish the school authorities to **TAKE NO ACTION OR TO:**

_____

_____

_____

_____