

**JAMES A. GARFIELD LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION**

NAME _____ TELEPHONE _____

ADDRESS _____ SCHOOL ATTENDING _____

_____ GRADE _____

PART I: TO GRANT CONSENT

To enable parents and guardians to authorize the provision of emergency medical treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother _____ Daytime Phone () _____

Father _____ Daytime Phone () _____

Other Name _____ Daytime Phone () _____

Name of a relative or child care provider _____

Relationship _____ Daytime Phone () _____

Address _____

I hereby give consent for the following medical care providers/local hospital to be called:

Doctor _____ Phone () _____

Dentist _____ Phone () _____

Medical Specialist _____ Phone () _____

Local Hospital _____ Phone () _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for any treatment deemed necessary by the above mentioned physicians.

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 my 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 _____

Part II: REFUSAL TO CONSENT

I do not give 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 the following action: _____

Date _____ Signature _____ Address _____
