PERRY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

Please Update As Needed

PERRY ELEMENTARY			
School Building	**Grade**	**DOB**	**Student Name**

Teacher	**Address**	☐ **Home Phone**

PURPOSE: To enable Parents/Guardians to authorize the provision of emergency treatment for children who become ill/injured while under school authority, when parents/guardians cannot be reached.

Student Cell Phone

**Please put a 1 in the box next to the number that we should call first in case of an emergency. Please put a 2 in the box next to box that we should call second in case we cannot reach someone at the first number. Add a 3 to the 3rd box and a 4 in the 4th.

Contacts

Contact Type	Name	Home Phone	Cell Phone
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Medical Conditions

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments:

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor ______________________ **Phone** ______________

Dentist ______________________ **Phone** ______________

Medical Specialist ______________________ **Phone** ______________

Hospital ______________________ **Phone** ______________

In the event that reasonable attempts to contact me have been unsuccessful I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available by any other licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physician or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date ______________ ***Signature of Parent/Guardian*** ______________________

Address ______________________

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

Date ______________ ***Signature of Parent/Guardian*** ______________________

Address ______________________