EMERGENCY MEDICAL AUTHORIZATION

LAKEWOOD LOCAL SCHOOLS

RESIDENTIAL PARENT OR GUARDIAN:

Mother's Name _____ (Daytime Phone)

Father's Name _____ (Daytime Phone)

Other's Name _____ (Daytime Phone)

Name of Relative or Childcare Provider:

_____

(Name) (Address) (Phone) (Relationship)

Student Name

_____

Address Street

_____

City Zip

_____

Telephone

_____

School Attended

Purpose – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:

Doctor _____ Phone Number _____

Dentist _____ Phone Number _____

Medical Specialist _____ Phone Number _____

Local Hospital _____ Phone Number _____

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 PHYSICIAL OR DENTIST: AND (2) THE TRANSFER 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.

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

Date _____ Parent Signature _____

_____

Address – Street City Zip

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 _____ Parent Signature _____

_____

Address – Street City Zip