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

EMERGENCY MEDICAL AUTHORIZATION

School District	Student Name	Grade

RESIDENTIAL PARENT OR GUARDIAN

Street Address

Mothers's Name ____________________ (Daytime Phone)

City Zip

Father's Name ____________________ (Daytime Phone)

Telephone

Other's Name ____________________ (Daytime Phone)

School Attended

Name of Relative or Childcare Provider:

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

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

PART I OR 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 ____________________ Emergency Room Phone ____________________

IN THE EVENT RESONABLE ATTEMPS 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 PHYSICAN 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 physicans 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 being taken, and any physical impairments to which a physician should be alerted;

(Date) (Signature of Parent/Guardian)

(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) (Signature of Parent/Guardian)

(Address – street) (City) (Zip)