EMERGENCY MEDICAL AUTHORIZATION

Date of Birth Please note bus even if student drives Bus # AM Bus # PM Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become injured while under school authority, when parents or guardians cannot be reached. * Student resides with (Check all that apply) Mother Father Stepparent Guardian Other Name Home Phone Work Phone Mobile Phone Father. Stepparent: Guardian: Name Home Phone Work Phone Mobile Phone 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: Dentist: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is available, by another 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 opinions of two (2) other licensed physicians 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 (2) other licensed physicians or dentist, and physician should be alerted: Date: Signature of Parent/Guardian:	dress			Grade		
Bus # AM Bus # PM Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become injured while under school authority, when parents or guardians cannot be reached. * Student resides with (Check all that apply) Mother Father Stepparent Guardian Other Mother: Name Home Phone Work Phone Mobile Phone Mother: Father: Address: Stepparent: Guardian: Phone: Mame of Relative or Childcare Provider: Address: Relationship to Child: Phone: PART ORANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called: Name/Phone Medical Specialist Doctor: Dentist Local Hospital: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is available, by another 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 opinions of two (2) other licensed physicians or denticoncurring 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 which a physician should be alerted: Date: Signature of Parent/Guardian:		· · · · · · · · · · · · · · · · · · ·		Date of Bir	th	
Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become injured while under school authority, when parents or guardians cannot be reached. * Student resides with (Check all that apply) Mother Father Stepparent Guardian Other Name	y, State, Zip			Please i	ote bus even if	student drives
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* Student resides with (Check all that apply) Mother Father Stepparent Guardian Other Name				Bus # PM		
* Student resides with (Check all that apply) Mother Father Stepparent Guardian Other Name						
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Mother: Stepparent: Stepparent: Address: Phone:		Name	Ho	me Phone	Mode Di-	T
Stepparent: Guardian: Name of Relative or Childcare Provider: Relationship to Child: PART LOR II MUST BE COMPLETED Name/Phone Name/Phone Name/Phone Medical Specialist: Dentist: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is available, by another 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 opinions of two (2) other licensed physicians or dent 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 which a physician should be alerted: Date: Signature of Parent/Guardian: PART II — REFUSAL TO CONSENT do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emerger reatment, I wish the school authorities to take the following action (use back of form if necessary):	Mother:		- 100	me Phone	vvork Phone	Mobile Phone
Relationship to Child: PART I OR II MUST BE COMPLETED PART I O GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called: Name/Phone Name/Phone Medical Specialist: Dentist: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration any treatment deemed necessary by above-named doctor, or, in the event the desi ignated preferred practitioner is available, by another 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 opinions of two (2) other licensed physicians or denticoncurring 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 which a physician should be alerted: Date:	Father:					
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Name of Relative or Childcare Provider: Relationship to Child: 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: Name/Phone Name/Phone Medical Specialist: Dentist: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is available, by another 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 opinions of two (2) other licensed physicians or dent concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts conceming the child's medical history including allergies, medications being taken, and any physical impairment which a physician should be alerted: Date: Signature of Parent/Guardian: PART II - REFUSAL TO CONSENT do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emerger reatment, I wish the school authorities to take the following action (use back of form if necessary):						
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