Child's Name_____ Date of Birth_____

EMERGENCY MEDICAL AUTHORIZATION FORM

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.

Parent or Guardian _____ Phone _____ _____

Parent or Guardian _____ Phone _____ _____

Emergency Contact_____ Phone _____ _____

Emergency Contact_____ Phone _____ _____

Please list any known allergies, medications being taken, and pertinent medical history or information about existing conditions that may affect your child at school.

_____
_____
_____

Child's Physician_____ Phone_____
Child's Dentist_____ Phone_____
Preferred Hospital_____

PART I OR II MUST BE COMPLETED

Part I: To Grant Consent

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not 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 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____
Signature of Parent/Guardian Date

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 Cool Springs Montessori authorities to take the following action:

_____

_____
Signature of Parent or Guardian Date