

EMERGENCY MEDICAL AUTHORIZATION FORM

Lancaster City Schools

School _____ Student's Name _____

Teacher _____ Street _____

Date of Birth: _____ City _____ Zip _____

Home Phone # () _____ 1st Cell # () _____ 2nd Cell # () _____

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 can not be reached.

Residential Parent or Guardian:

Mother's Name _____ First Last	Place of Employment: _____ Work Phone () _____ Place of Employment: _____ Work Phone () _____ Place of Employment: _____ Work Phone () _____
Father's Name _____ First Last	
Other's Name _____ First Last	

Name of Relative or Childcare Provider:

Name _____	Relationship _____
Address _____	Daytime Phone () _____

Alternate Person to be notified:

# 1 Name _____ Address _____ Cell Phone # () _____	Relationship _____ Telephone () _____ Work # () _____
# 2 Name _____ Address _____ Cell Phone # () _____	Relationship _____ Telephone () _____ Work # () _____
# 3 Name _____ Address _____ Cell Phone # () _____	Relationship _____ Telephone () _____ Work # () _____

PART I OR II ON REVERSE SIDE MUST BE COMPLETED.

NOTE: NO ONE will be permitted to pick up your child unless his/her name appears on this form, or we have written confirmation from Parent or Guardian. **This includes an evacuation or terrorist alert.**

PART I: TO GRANT CONSENT

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

Physician _____ Telephone (____) _____

Dentist _____ Telephone (____) _____

Medical Specialist _____ Telephone (____) _____

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 doctors or, in the event the designated preferred 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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please give facts concerning the student's medical history, including allergies and medications being taken:

Medical condition(s) we should be made aware of _____

Medicine student is currently taking (amount/when taken) _____

Allergies _____

Any other needed information regarding student _____

Date _____ Signature of Parent/Guardian _____

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent(s) are contacted and the instructions on this form are followed. In extreme emergencies, arrangements may be made for a student's immediate hospitalization whether or not the parent(s) can be reached. 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 _____