EMERGENCY MEDICAL AUTHORIZATION
LOWELLVILLE K-12 SCHOOL

PLEASE PRINT CLEARLY AND PRESS FIRMLY SO LAST PAGE IS LEGIBLE

CHILD'S NAME ______________________________ Bus No ____________
Last First Middle

ADDRESS ______________________________ Phone No ____________

CITY/STATE/ZIP ______________________________ Social Security # ____________

Age/Date of Birth ________ / ____________ Grade/Homeroom # ________ / ________

PLEASE CONTACT THE FOLLOWING IN CASE OF EMERGENCY "COMPLETE ALL FOUR SPACES" Contact will be made in the order in which they are listed.

1. ______________________________
Name Relationship

____
Home Phone Business Phone

____
Cell Phone Pager

2. ______________________________
Name Relationship

____
Home Phone Business Phone

____
Cell Phone Pager

3. ______________________________
Name Relationship

____
Home Phone Business Phone

____
Cell Phone Pager

4. ______________________________
Name Relationship

____
Home Phone Business Phone

____
Cell Phone Pager

5. TO GRANT CONSENT

In the event reasonable attempt to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physicians below or, if they are not available, by another licensed physician or dentist. I give my consent for my child to be transferred to the hospital below, or any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentists concerning in the necessity of 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. ______________________________

____

____
Preferred Physician (Phone)

____
Preferred Dentist (Phone)

____
Preferred Hospital (Phone)

____
Signature of Parent or Guardian Date

6. REFUSAL OF CONSENT (Fill out ONLY if you haven't completed No. 5 above)

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 no action or to

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____
Signature of Parent or Guardian Date

White Nurse's File (1) Copy to the following: Office, Field Trip/Teacher, Bus Driver