EASTWOOD SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

GRADE _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority.

The following individuals are to be contacted in the order specified. Parent's E-mail: _____

1. Name:_____(Home)_____
   Place of Work:_____(Work)_____
   Relationship:_____(Cell)_____

2. Name:_____(Home)_____
   Place of Work:_____(Work)_____
   Relationship:_____(Cell)_____

3. Name:_____(Home)_____
   Place of Work:_____(Work)_____
   Relationship:_____(Cell)_____

_____
STUDENT'S FULL NAME

_____
P. O. BOX/STREET

_____
CITY, STATE, ZIP CODE

_____
PHONE

_____ _____
Date of Birth Birth City

_____
Date of last DPT or Tetanus Booster

CONSENT FOR TREATMENT – PART I

In the event that reasonable attempts to contact the above individuals have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment _____
   deemed necessary by Preferred Physician Phone #

OR

_____
Preferred Dentist Phone #

In the event that the designated practitioner is not available, by another physician or dentist.

2. The transfer of the student to_____(preferred hospital) or 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 list important facts concerning the student's medical history including allergies, medications currently being taken, and any physical impairment to which a physician should be alerted.

_____

_____

Date_____ Parent/Guardian Signature_____

REFUSAL TO CONSENT-PART II **(Do not complete if you completed part I)**

I do not give consent for emergency 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:

_____

Date_____ Parent/Guardian Signature_____