EMERGENCY RECORD DATA

Name of Child _____ Grade _____

Address _____

Phone Number _____ Sex ____ M ____ F

Name of Father _____ Name of Mother _____

Address of parent (if different from child) _____

Parent's Place of Employment and phone numbers _____

_____

Name & phone number of relatives or friends to contact in an emergency

1. _____

2. _____

EMERGENCY MEDICAL AUTHORIZATION PART I OR PART II MUST BE COMPLETED

PART I — TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), 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 _____ (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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

_____

Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 the school authorities to take no action or to:

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

PPH2

_____

Address