

# 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:

**Past Medical History** \_\_\_\_\_  
\_\_\_\_\_

**Medicine student is currently taking** \_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_