



New Albany – Plain Local Schools

**EMERGENCY MEDICAL AUTHORIZATION**

Student Name: \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

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 cannot be reached.

	Residential Parent or Guardian:	Home Phone	Work Phone	Cell Phone
Mother's Name	_____	_____	_____	_____
Father's Name	_____	_____	_____	_____
Other's Name	_____	_____	_____	_____

Name of Relative or Childcare Provider Name	
Name _____	Relationship _____
Address _____	Home Phone _____
_____	Work Phone _____
_____	Cell Phone _____

**PART I OR II MUST BE COMPLETED**

**PART I - TO GRANT CONSENT**

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

Doctor _____	Phone _____
Dentist _____	Phone _____
Medical Specialist _____	Phone _____
Local Hospital _____	Phone _____

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 doctor, 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.

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 \_\_\_\_\_

**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 the following action:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Address \_\_\_\_\_