Emmanuel Christian Academy
Emergency Medical Authorization

Student Name: ____________________________________ Date of Birth: ______________ Grade: _______________

Home Address: ____________________________________ Home Phone: ______________

____________________________________ Student Email: ____

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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.

********LIST PARENTS FIRST, THEN OTHER RESPONSIBLE ADULTS WHO MAY BE CONTACTED AND/OR ARE PERMITTED TO TAKE THE CHILD FROM SCHOOL IN CASE OF AN EMERGENCY:**

Contact Name	Relationship to child	Home Phone	Work/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 _______________________________________

----------Turn this form over to complete second side----------

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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.

Allergies - ____
Medications - ____
Physical Impairments - ____
Other Pertinent Information - ____

Date________________________ Signature of Parent/Guardian_________________________________
Address____

<u>PART II - REFUSAL TO CONSENT</u>

I do not give my consent for emergency medical treatment, I wish the school authorities to take the following action:
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Date________________________ Signature of Parent/Guardian_________________________________
Address____