

Emergency Medical Authorization Form



Minford High School Athletic Department

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

Student Name _____ **Birthdate** _____ **Grade** _____

Does student drive to school? **Yes** _____ **No** _____ Is Student Bussed? **Yes, Bus #** _____ **No, other** _____

Mailing Address _____ 911 Address _____

Telephone () _____ Home E-Mail Address _____

Parent/ Guardian Information

Mother's Name _____ **Home/Cell Number** _____ **Work Number** _____

Father's Name _____ **Home/Cell Number** _____ **Work Number** _____

Guardian Name (if applicable) _____ **Home/Cell Number** _____ **Work Number** _____

Additional Contact Persons and phone #'s (in the event the above cannot be reached to grant permission to leave school or pick up from school)

Name: _____ **#** _____ **Name:** _____ **#** _____

Name: _____ **#** _____ **Name:** _____ **#** _____

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

Physician _____ 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 doctors, or, in the event the designated 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 dentist, 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 impairment to which a physician should be alerted: _____

Date: _____ Signature of Parent/ Guardian _____

If you completed and signed Part I to grant consent, please do not sign Part II

Part II: REFUSAL TO CONSENT I do **not** give my consent for the 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/ Guardian _____