2016-2017 Emergency Medical Authorization - The Graham School

Student Name: ____ Grade: ________________
Address: ____(including city and zip)
Student's Cell Phone No.: ___________________________________ Home Phone: ______________________
Student's E-Mail: ____

Purpose: to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent(s)/guardian(s) cannot be reached. In the event of an emergency, please call:

Name (Mother): _____________________________________ Home phone: _________________________
Work phone: _____________________ Cell phone: _________________________
E-Mail: _________________________

Name (Father): ______________________________________ Home phone: _________________________
Work phone: _____________________ Cell phone: _________________________
E-Mail: __________________________

Name: ____ Relationship: ______________________________
Home phone: ____________________Work phone: ____________________Cell phone: _________________________

In the event reasonable attempts to contact the above mentioned have been unsuccessful, I hereby give my consent for:

1) The administration of any treatment deemed necessary by:

1. Preferred Physician: _________________________ Phone: _______________
2. Preferred Dentist: ___________________________ Phone: _______________
3. M.D. Specialist: _____________________________ Phone: _______________

In the event the designated preferred practitioner(s) are not available, by another licensed physician or dentist: and

2) Transfer of the child to:
(Preferred hospital): _____________________________ Phone: _________________ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of the two licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Legal Guardian: ___________________________________ **Date:** _______________________

Food Allergies : _______________________________ Medicine Allergies: _______________________________
Insect Allergies: _______________________________ Other Allergies: _________________________________
Is EPI-PEN required? Yes No

Current Medications:
Name: ___________________________ Dosage: _____________________ Frequency: ________________
Name: ___________________________ Dosage: _____________________ Frequency: ________________
Name: ___________________________ Dosage: _____________________ Frequency: ________________

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 school authorities TAKE NO ACTION or TO: _________________________________

Signature of Legal Guardian: _____________________________________ **Date:** __________________________