GEMS

Graham Primary School

Emergency Medical Authorization

Student Name _____ Grade_____
Address _____ Date of Birth _____
City, St, Zip _____ Home Phone _____

Purpose: To enable parents/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. In the event of an emergency, please call:

Name _____(Mother) Home Phone _____
Work Phone_____
Cell/Pager _____

Name _____(Father) Home Phone _____
Work Phone_____
Cell/Pager _____

Name _____ Home Phone _____
Relationship _____ Work Phone_____
Cell/Pager _____

*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) the transfer of the child to (preferred hospital) _____ Phone_____
or any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, 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_____

Health Concerns (Diabetes, Asthma, etc.) _____
_____
_____

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 to TAKE NO ACTION or TO: _____
_____

Signature of Legal Guardian_____ **Date**_____

**This institution is an equal opportunity provider*