EMERGENCY MEDICAL AUTHORIZATION
KEYSTONE LOCAL SCHOOLS

_____ _____ _____
(Student Name) (Grade) (Telephone Number)

_____ _____
(Address) (School Attended)

Purpose – To enable parent to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART 1 (TO GRANT REQUEST)

In the event reasonable attempts to contact me at _____, or _____
(Daytime Phone Number) (Other Parent)

at _____, or _____ at_____ , or
(Daytime Phone Number) (Relative or Childcare Provider) (Daytime Phone Number)

_____, or _____ have been unsuccessful,
(Other Name) (Daytime Phone Number)

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 _____

This authorization does not cover major surgery unless the medical opinion of two other physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:
_____
_____

Parent/Guardian Signature: _____ Date: _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to:

_____
_____

Parent/Guardian Signature: _____ Date: _____