

**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: _____