NORTH FORK LOCAL SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION FORM

**PLEASE NOTE: A COPY OF THIS FORM WITH PARENT/GUARDIAN SIGNATURE IS EQUIVALENT TO ORIGINAL

Student's Name (Last, First, MI) **Birthdate** **Grade**

Student's Address **City, State, Zip** **Parent's Email**

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/guardians cannot be reached.

Parent/Guardian gives District permission to contact the following:

RELATIONSHIP	NAME	HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER
Mother/Guardian					
Mother/Guardian Address (If different from student):					
Father/Guardian					
Father/Guardian Address (If different from student):					
Stepmother					
Stepfather					
In the event that the above contacts cannot be reached, list two people to whom you authorize the school to release your ill or injured child:					

Legal Custodian or Residential Parent for School Placement: _____

Student lives with: Both Parents I Mother Only I Father Only I Shared Parenting I Guardian/Foster/Host I Grandparent I Mother-Stepfather I Father-Stepmother I Self

EMERGENCY MEDICAL AUTHORIZATION – **Part I OR Part II** below must be completed.

PART I – GRANT TO CONSENT

Doctor: **Phone Number:**

Dentist: **Phone Number:**

Hospital: **ER Phone Number:**

I hereby give consent for the above medical care providers and local hospital to be called. In the event reasonable attempts to contact me or the other parent have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or, in the event the designated preferred 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 medial opinions of two other licensed physicians or dentists, 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 impairments to which a physician should be alerted: _____

_____

Signature of Parent/Guardian: Date:

Parent/Guardian's Address:

PART II – REFUSAL TO CONSENT (Do not complete if you have completed Part I above)

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 the following action: _____

_____

Signature of Parent/Guardian: Date:

Parent/Guardian's Address: