GOOD SAMARITAN EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name ______________________________

Address ______________________________

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Telephone ______________________________

Cell Phone # ______________________________

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name ______________________ Daytime Phone ______________

Father's Name ______________________ Daytime Phone ______________

Other's Name ______________________ Daytime Phone ______________

Name of Relative or Childcare Provider:

______________________________ Relationship ______________

Address ______________________________ Telephone ______________

PART I or II MUST BE COMPLETED

Part I - **To Grant Consent**

I hereby give consent for the following medical providers and local hospital to be called:

Doctor ______________________________ Phone ______________

Dentist ______________________________ Phone ______________

Medical Specialist ______________________________ Phone ______________

Local Hospital ______________________________ Phone ______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named 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 medical 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 to:

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______________________________ ______________________________

Signature of Parent/Guardian Date Address ______________________________

Part II - **Refusal To Consent**

I DO NOT give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the school authorities to take the following action:

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______________________________ ______________________________

Signature of Parent/Guardian Date Address ______________________________