

GOOD SAMARITAN EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name	_____
Address	_____ _____
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:

Address	_____	Relationship	_____
		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:

Signature of Parent/Guardian	Date	Address	_____
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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:

Signature of Parent/Guardian	Date	Address	_____
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