BIO-MED
SCIENCE ACADEMY

# Emergency Medical Authorization Form

Student Name_____Address_____
Phone_____

*Purpose - To enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent(s) or guardian(s) cannot be reached.*

Residential Parent/Guardian:

Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Daytime Phone: _____
Other's Name: _____ Daytime Phone: _____
Name of Relative or Childcare Provider: _____ Relationship: _____

**Part I OR Part II Must Be Completed**
PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers of 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 (2) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated practitioner is not available, by another licensed physician or dentist, concurring in the necessity for 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:

_____
_____
_____

**Do Not Complete Part II if you have 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 the following action:

_____
_____
_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____