SOUTHWEST LOCAL SCHOOL DISTRICT - EMERGENCY MEDICAL AUTHORIZATION

Student's Street Address City Talephone PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while und school authority, when parents or guardians cannot be reached. Residential Parent or Guardian Mother's Name Father's Name Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Local Hospital In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the diministration of any treatment deemed necessary by above-named doctor, or in the event the designated prefuractitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp assonably accessible. Phis authorization does not cover major surgery unless the medical opinions of two other licensed physicians or tentists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recomergency treatment, I wish the school authorities to take the following action:	Student's Name			Date of Birth	School Student Attends	
PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while und school authority, when parents or guardians cannot be reached. Residential Parent or Guardian Mother's Name Mother's Daytime Phone Number Father's Name Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Dentist Name Phone Number Local Hospital Emergency Room Phone Number Local Hospital Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the diaministration of any treatment deemed necessary by above-named doctor, or in the event the designated preference titioner is not available, by another licensed physicians or dentist, and (2) the transfer of the child to any hosy easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Cacts concerning the child's medical history including allergies, medications being taken, and any hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I)						
Residential Parent or Guardian Mother's Name Mother's Name Mother's Name Father's Name Father's Name Name of Relative or Childcare Provider Name Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Dentist Name Phone Number Local Hospital Emergency Room Phone Number 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 preference things authorization does not cover major surgery unless the medical opinions of two other licensed physicians or lentists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury reserved.	Student's Street Addre	SS		City	Telephone	
Mother's Name Father's Name Father's Daytime Phone Number Father's Daytime Phone Number Name of Relative or Childcare Provider Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) Thereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Local Hospital Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful. I hereby give my consent for (1) the diministration of any treatment deemed necessary by above-named doctor, or in the event the designated prefer fractitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART III IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury results.	PURPOSE - To enable parents school authority, when parents o	and guardians to auth r guardians cannot be	norize the provision reached.	n of emergency treatment	t for children who become ill or injured while under	
Father's Name Name of Relative or Childcare Provider Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) Thereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Dentist Name Phone Number Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the diministration of any treatment deemed necessary by above-named doctor, or in the event the designated preferactitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury results.	Residential Parent or G	uardian				
Name of Relative or Childcare Provider Name	Mother's Name			Mother's Day	time Phone Number	
Name Relationship Street Address City Zip Code Phone Number PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name Phone Number Dentist Name Phone Number Local Hospital Emergency Room Phone Number Local Hospital Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the diministration of any treatment deemed necessary by above-named doctor, or in the event the designated preferenctitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART II) do not give my consent for emergency medical treatment of my child. In the event of illness or injury results in the consent for emergency medical treatment of my child.	Father's Name			Father's Davti	ime Phone Number	
PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name	Name of Relative or Chi	ildcare Provider	,	,		
PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED) I hereby give consent for the following medical care providers and local hospital to be called: Doctor/Specialist Name	Name			Relationship		
Dentist Name Phone Number Dentist Name Phone Number Dentist Name Phone Number Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the idministration of any treatment deemed necessary by above-named doctor, or in the event the designated preferractitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospeasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury restricts.	Street Address	City	Zip Code		Phone Number	
Dentist Name Phone Number Dentist Name Phone Number Dentist Name Phone Number Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the idministration of any treatment deemed necessary by above-named doctor, or in the event the designated preferractitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospeasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury restricts.	PA	ART I TO GRAN	T CONSENT	(PART LOR ILMUS	ST RE COMPLETED)	
Dentist Name Phone Number Emergency Room Phone Number 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 preference is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hose easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury red			1 CONCENT	(I AIVI I OIVII III)	ST BE COMPLETED)	
Dentist Name Phone Number	hereby give conse	nt for the followi	ng medical ca	re providers and lo	cal hospital to be called:	
Emergency Room Phone Number In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the indiministration of any treatment deemed necessary by above-named doctor, or in the event the designated prefer practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hose easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or entists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recommendations.	Doctor/Specialist Name		-	Phone Number		
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 prefer practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp easonably 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 impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recommendations.	Dentist Name		-	Phone Numbe	r	
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 preference is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hosp easonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or lentists, 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 hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recommendations.	Local Hospital		- .	Emergency Ro	oom Phone Number	
Facts concerning the child's medical history including allergies, medications being taken, and any hysical impairment to which a physician should be alerted: Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recompleted.	idministration of any treat oractitioner is not available	ment deemed no	ecessary by a	bove-named doctor	r, or in the event the designated preferred	
Date Signature of Parent/Guardian PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury recompleted.	his authorization does no entists, concurring in the	ot cover major su necessity for suc	irgery unless t ch surgery, ar	he medical opinion e obtained prior to t	s of two other licensed physicians or the performance of such surgery.	
PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I) do not give my consent for emergency medical treatment of my child. In the event of illness or injury rec	acts concerning the hysical impairment to wh	e child's med ich a physician s	lical histor hould be aler	/ including allergies ed:	s, medications being taken, and any	
do not give my consent for emergency medical treatment of my child. In the event of illness or injury red				Date	Signature of Parent/Guardian	
do not give my consent for emergency medical treatment of my child. In the event of illness or injury red	PART II IS A REFU	JSAL TO CONS	ENT (DO NO	T COMPLETE PAR	RT II IF YOU COMPLETED PART I)	
	do not give my cons	sent for emerge	ency medical t	reatment of my chi	ld. In the event of illness or injury requiri	
Date Signature of Parent/Guardian				Date	Signature of Parent/Guardian	