

Emergency Medical Authorization Reading Community Schools

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

Student _____
 Address _____
 Home phone _____
 School _____

Part I (Complete this section only if you wish to grant consent)

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 the designated preferred physician or dentist, 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 preferred hospital or any hospital reasonably accessible.

Residential Parent of Guardian

Mother	Home phone	Work phone
Father	Home phone	Work phone
Other Contact	Home phone	Work phone
Address		Relationship
Other Contact	Home phone	Work phone
Address		Relationship
Preferred Doctor		Phone
Address		
Preferred Dentist		Phone
Address		
Preferred Local Hospital		Phone

The authorization does not cover major surgery unless the medical opinions of two 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:

Parent signature _____ Date _____

Part II (Complete this section only if you wish to refuse 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 no action or to:

Parent signature _____ Date _____

Complete either Part I or II -- Do not fill out both parts.