AUTHORIZATION TO SCHOOL
EMERGENCY MEDICAL TREATMENT FOR MINOR

Authorization

I, _____, of _____ (address), am the _____ (father/mother/legal guardian) of _____, a minor, of _____ (address), who attends _____ (name of school), located at _____ (address).

In the event all reasonable attempts by authorized school personnel to contact me at _____ (phone number) or to contact _____ (other parent/guardian) at _____ (phone number) have been unsuccessful, I give my consent for:

1. The administration of any treatment deemed necessary by _____ (preferred physician) or _____ (preferred dentist), or, in the event the appropriate preferred practitioner is not available, by another licensed physician or dentist; and

2. The transfer of the minor to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

The following information is needed by any hospital or practitioner not having access to the minor's medical history:

Allergies: _____

Medication being taken: _____

Date of last tetanus shot: _____

Physical impairments: _____

Other pertinent facts to which physician should be alerted:

_____

_____ _____

(Signature) (Date)