

2011-2012 Emergency Medical Authorization - The Graham School

Student Name: _____ Grade: _____
Address: _____ (including city and zip)
Student's Cell Phone No.: _____ Home Phone: _____
Student's E-Mail: _____

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)/guardian(s) cannot be reached. In the event of an emergency, please call:

Name (Mother): _____ Home phone: _____
Work phone: _____ Cell phone: _____
E-Mail: _____

Name (Father): _____ Home phone: _____
Work phone: _____ Cell phone: _____
E-Mail: _____

Name: _____ Relationship: _____
Home phone: _____ Work phone: _____ Cell phone: _____

In the event reasonable attempts to contact the above mentioned have been unsuccessful, I hereby give my consent for:

1) The administration of any treatment deemed necessary by:

1. Preferred Physician: _____ Phone: _____
2. Preferred Dentist: _____ Phone: _____
3. M.D. Specialist: _____ Phone: _____

In the event the designated preferred practitioner(s) are not available, by another licensed physician or dentist: and

2) Transfer of the child to:

(Preferred hospital): _____ Phone: _____ or any hospital reasonably accessible.

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

Signature of Legal Guardian: _____ **Date:** _____

Food Allergies : _____ Medicine Allergies: _____

Insect Allergies: _____ Other Allergies: _____

Is EPI-PEN required? Yes No

Current Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

I hereby request and give my permission to the school designee to assist in administering Over the Counter medication to my child. Over the Counter medications available are Tylenol, Advil, Pepto-Bismol, Tums and cough drops.

Signature of Legal Guardian: _____ **Date:** _____

Health Concerns (Diabetes, Asthma, etc.): _____

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 school authorities TAKE NO ACTION or TO: _____

Signature of Legal Guardian: _____ **Date:** _____