Sebring Local Schools
Emergency Medical Authorization

Birthday ___________ Grade ________ Eye Color _______ Student ____

Address ____

School _____________________________________ Home Telephone (____)____________ Cell # (___)______________

Purpose-To enable parents/guardians to authorize emergency treatment for children who become ill/injured during the school day, when parents or guardians cannot be reached and to up-date school records.

Residential Parent/Guardian:

Mother's Name: __________________ Employed at: ______________________________ Work Phone: ___________________

Father's Name: __________________ Employed at: ______________________________ Work phone: ___________________

Other's Name: __________________ Relationship: ______________________________ Phone: _________________________

Please list 2 other Relatives or Childcare Providers to call if above are not available:

Name: _______________________________ Relationship: _________________________ Phone: _________________________

Name: _______________________________ Relationship: _________________________ Phone: _________________________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: ____

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In the morning, if your child has a fever, pain or rash, or has an eye that is matted or red with drainage, DO NOT send him/her to school. Your doctor should check these conditions.

Part I: TO GRANT CONSENT (Parent must sign either Part I or Part II)

I hereby give consent for the following medical care providers and local hospital to be called:

Physician ______________________ Phone _______________________

Dentist ________________________ Phone _______________________

Specialist ______________________ Phone _______________________

Hospital _______________________ Phone _______________________

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 above-named doctors, 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 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.

Signature of Parent/Guardian ____ Date ______________

Part II: REFUSAL TO CONSENT

I do ***NOT*** give consent for emergency medical treatment of my child. In the event of illness/injury requiring medical treatment, I wish the school authorities to take the following action if *unable to contact me*:

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Signature of Parent/Guardian ____ Date ____________________