



LAKEWOOD CITY SCHOOLS

Emergency Medical Authorization Form

Child's Name _____
LAST _____ FIRST _____ Birthdate _____
Homeroom No. _____ LHS Only _____
HOUSE NUMBER _____

PLEASE COMPLETE FRONT AND BACK OF THIS FORM

School _____ Student _____
Address _____
_____ Zip _____
Home Phone (_____) _____

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.

RESIDENTIAL PARENT OR GUARDIAN

Mother's Name _____ Daytime Phone () _____
Cell Phone () _____
Father's Name _____ **Daytime Phone** () _____
Cell Phone () _____
Other's Name _____ Daytime Phone () _____
Cell Phone () _____

*** PRIMARY PHONE NUMBER TO CALL IN CASE OF EMERGENCY: () _____**

Name of Relative or Childcare Provider:
_____ Relationship _____
Address _____ Phone _____

PLEASE COMPLETE FRONT AND BACK OF THIS FORM

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT

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

Doctor _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Medical Specialist _____ Phone (_____) _____

Emergency Room

Local 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 above named doctor, or in the event that 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.

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

Date _____ Signature of Parent/Guardian _____
Address _____

PART II – 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 the school authorities to take the following action:

Date _____ Signature of Parent/Guardian _____
Address _____
