SOUTHEAST LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION
(Use Black Ink)

Student Name	Primary Contact #	Student Cell Phone Number
Street Address	City Zip	Grade / Teacher Name
Mother/Legal Guardian Name	Day Phone Cell	Email
Father/Legal Guardian Name	Day Phone Cell	Email

Student resides with: ___Both parents ___Mother ___Father ___Guardian (be specific):_____
*If the custody of the child has been altered since birth (divorce, foster, etc), a copy of the court documentation must be on file at school.

Siblings (list full name/grade level of any additional siblings in the home of residence):_____

_____

****Please list all other names and phone numbers of people your child may be released to. List in the order you would like us to contact. Additional names may be added on the reverse side of this form.**

Name	Phone Number	Relationship (ie: Step-parent, Sitter, Grandparent, Friend)
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***YOU ARE RESPONSIBLE TO INFORM US OF ANY CHANGES**

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.

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred physician) or Dr._____ (preferred dentist), or in the event the designated 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. 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 taken, and any physical impairments to which physician should be alerted:_____.

Printed name of Custodial Parent/Guardian	**Signature** of Custodial Parent/Guardian	Date

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
PART II REFUSAL TO CONSENT

I do not give my consent for emergency treatment for my child. In the event of illness or injury requiring treatment, I wish the school authorities take no action or to:_____.

Printed name of Custodial Parent/Guardian	**Signature** of Custodial Parent/Guardian	Date