Emergency Medical Authorization

As mandated by House Bill 639
OLMSTED FALLS SCHOOLS

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.

Student ID	Student Last Name	Student First Name	Birth Date	Grade	HRM	Phone Number

Street Address	Apartment	Municipality	Zip Code

Mailing Address

Parent/Guardian Information

Custody: Living With:

Parent/Guardian #1	Parent/Guardian #2	Parent/Guardian #3
Relationship:	Relationship:	Relationship:
Address (if different from student):	**Address (if different from student):**	**Address (if different from student):**
Wk Phone # / Cell Phn # / Hm Phone #	Wk Phone # / Cell Phn # / Hm Phone #	Wk Phone # / Cell Phn # / Hm Phone #
E-Mail:	E-Mail:	E-Mail:

Friend, Relative, or Childcare Provider

#1 Name: Relationship:
Address: Daytime Phone: ( ) Other: ( )

#2 Name: Relationship:
Address: Daytime Phone: ( ) Other: ( )

If any of the above information changes during the school year, please inform the office.

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

Doctor: **Phone:**
Dentist: **Phone:**
Preferred 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 the designated preferred physician is not available, by other 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.

Please list in the space below facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician or hospital personnel should be alerted:

Date: Signature of Parent/Guardian:
Address

PART II - REFUSAL TO CONSENT

(Do not complete if you completed Part I)

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 authorities to take the following action:

Date: Signature of Parent/Guardian:
Address