2004-2005

Regina High School

EMERGENCY MEDICAL AUTHORIZATION

Student Name ________________________________ Grade Level _____

Address ____

City/State ________________________________ Zip______________

Telephone ____

Purpose - To enable parents to authorize the emergency treatment for children who become ill or injured while under school supervision.

Residential Parent or Guardian:

Mother __________________________ Daytime Phone _____________
First Last

Father __________________________ Daytime Phone _____________
First Last

Other Name __________________________ Daytime Phone _____________
First Last

Mother Living with family ❑ yes ❑ no Father Living with family ❑ yes ❑ no

Name of relative or child care provider who is also
authorized to pick up your daughter from school:

Relationship ____

Address ____

City/State ________________________________ Zip_____________

Daytime Phone ____

Part I or Part II must be completed
(See page 2)

PART I: TO GRANT CONSENT

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

Physician ___________________________ Phone ___________________________

Dentist ___________________________ Phone ___________________________

Medical Specialist ___________________ Phone ___________________________

Local Hospital ______________________ Emergency Room 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 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.

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

Medical Insurance Information:

Company: ________________________________ Plan Identification No.:____________________

Identification No. Of Covered Employee, in Employer Plan: ________________________________

________________________________ ________________________________

Parent and/or Legal Guardian Signature *Parent and/or Legal Guardian Signature*

____________________ ____________________

Date *Date*

________________________________ ____________________

Student (over age 18) *Date*

(if unable to make medical decision at that time)

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:

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________________________________ ________________________________

Parent and/or Legal Guardian *Parent and/or Legal Guardian*

________________________________ ________________________________

Street *Street*

________________________________ ________________________________

City, State, Zip *City, State, Zip*

____________________ ____________________

Date *Date*