

Emergency medical authorization (complex)

# ROSWELL HIGH SCHOOL

## EMERGENCY MEDICAL AUTHORIZATION

\_\_\_\_\_  
Student's Name                      Date of Birth                      Roswell High School                      \_\_\_\_\_  
School Attending                      Bus #

\_\_\_\_\_  
Address                      Zip                      Telephone #                      Neighbor or Alternate Person

\_\_\_\_\_  
Parent's Custodian's Name                      (If unlisted, circle the telephone #)                      Telephone # where alternate can be reached

\_\_\_\_\_  
Custodial Parent in case of separation                      Grade                      Neighbor or Alternate Person

\_\_\_\_\_  
Telephone # where Alternate can be reached

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured under school authority. When parents cannot be reached.

### Part I or II must be completed Part I – TO GRANT CONSENT

In the event reasonable attempts to contact me \_\_\_\_\_ at \_\_\_\_\_ or \_\_\_\_\_  
Name of Parent                      Phone #  
\_\_\_\_\_ at \_\_\_\_\_ have been unsuccessful, I hereby give my consent

Name of other Parent                      Phone #  
for (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_  
phone # \_\_\_\_\_ (preferred physician) or Dr. \_\_\_\_\_  
phone # \_\_\_\_\_ (preferred dentist). 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 \_\_\_\_\_  
phone # \_\_\_\_\_ (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 before surgery is performed

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

\_\_\_\_\_  
Date                      Signature of Parent or Custodian

If you wish school to take no emergency medical action \_\_\_\_\_  
Do not sign this portion but fill out below                      Address

### Do not complete Part II - If you completed Part I PART 2 – REFUSAL TO CONSENT

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

\_\_\_\_\_  
Date                      Signature of Parent/Guardian

Address: \_\_\_\_\_