EDISON LOCAL SCHOOL DISTRICT
Emergency Medical Authorization

School ___________________________ Student______________________________
Teacher___________________________ Address______________________________
Grade______ Homeroom___________ City___________________ Zip__________
Birthdate_________________________ Telephone_(____)_____________________

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 (_____)____ _____________
First Last
Father's Name ______________________ Daytime Phone (_____)_____________________
First Last
Other's Name _______________________ Daytime Phone (_____)_____________________

Name of Relative or Childcare Provider
____________________________________ Relationship _____________________________
Address______________________________ Daytime Phone (_____)____________________
City ___________________ Zip ________

PART I OR II MUST BE COMPLETED ON REVERSE SIDE

Medical History

Physical Impairments: ____
Treatment: ____
Allergies: ____________________________ Treatment: ______________________________
Asthma: ____________________ Treatment: _______________________________________
Reaction to bee stings: _________ Treatment: ______________________________________

Please note: All medications brought to school must be accompanied by a physician's order and written permission by the parent/guardian.
Please list medications being taken – Indicate taken at home or at school:

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 (_____)____________________________________
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 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.

Signature of Parent/Guardian ____ Date ___________________

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:

Signature of Parent/Guardian ____ Date ____________________