

**School Health Services  
Emergency Medical Authorization  
St. Mark School  
2016/2017**

Student's Last Name \_\_\_\_\_ Student 's First Name \_\_\_\_\_

Street Address \_\_\_\_\_ City, Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Purpose:** To enable parents/guardian to authorize emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

**PART 1 OR PART 2 MUST BE COMPLETED.**

**PART 1-TO GRANT REQUEST**

In the event reasonable attempts to contact me at \_\_\_\_\_ or \_\_\_\_\_  
(Phone) (Other Parent/Guardian)

at \_\_\_\_\_ have been unsuccessful, I hereby give my consent for:  
(Phone)

(1) Administration of any treatment deemed necessary by

Dr. \_\_\_\_\_ or Dr. \_\_\_\_\_  
(Physician) (Dentist)

or, in the event the designated preferred practitioner is not available,  
by another licensed physician or dentist:

(2) transfer of my child to \_\_\_\_\_ or any hospital reasonably assessible.  
(Preferred Hospital)

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery is performed.

**Fact concerning my child's medical history, including allergies, medication being taken, and any physical impairment to which a physician should be alerted:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**PART 2 -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 no action or to:

\_\_\_\_\_  
\_\_\_\_\_

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

\*\*\*\*\*OVER\*\*\*\*\*