



Emergency Medical Authorization

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under OMEA authority, when parents or guardians cannot be reached.

Student Name _____	Phone # _____
Address _____	School District _____
_____	School Attending _____
Birth Date _____ Sex M F	Grade _____
Handicap or Disability _____	
Please describe any special needs: _____	

Residential Parent or Guardian

Mother _____	Day Ph # _____	Cell # _____
_____	Email _____	Pager # _____
Father _____	Day Ph # _____	Cell # _____
_____	Email _____	Pager # _____
Other Name _____	Day Ph # _____	
Name of Relative or Childcare Provider _____		
Address _____	Phone # _____	
_____	Relationship _____	

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

Doctor _____	Phone # _____
Dentist _____	Phone # _____
Medical Specialist _____	Phone # _____
Hospital _____	Phone # _____

PLEASE COMPLETE PART I OR PART II—NOT BOTH

Part I—To Grant Consent

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 the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion 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: _____

Date _____ Parent or Guardian Signature _____

Address _____

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 OMEA authorities to take no action or to: _____

Date _____ Parent or Guardian Signature _____

Address _____