

# Summer Enrichment Academy

## EMERGENCY MEDICAL AUTHORIZATION (Grades 2-5)

Student Medical form must be completed to participate in the Summer Enrichment Academy

(Please complete a separate form for each child attending)

Student Name \_\_\_\_\_

School District \_\_\_\_\_

Student's Home Address (include PO Box) \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Student's Home Phone \_\_\_\_\_

School Attended \_\_\_\_\_

Mother's Name \_\_\_\_\_

Address (if different from student's) \_\_\_\_\_

Mother's Daytime Phone Number \_\_\_\_\_

Father's Name \_\_\_\_\_

Address (if different from student's) \_\_\_\_\_

Father's Daytime Phone Number \_\_\_\_\_

Guardian (if applicable) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

\*Name of Relative or Childcare Provider \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

\*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.

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

### PART I OR PART II MUST BE COMPLETED

#### PART I TO GRANT CONSENT

In the event reasonable attempts to contact me, other parent or guardian have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the listed doctor, dentist, or medical specialist, or, in the event the designated preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer of the child to the above 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 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:

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

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

#### PART II REFUSAL TO CONSENT (Do not complete if you completed Part I.)

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 or Guardian \_\_\_\_\_

Date \_\_\_\_\_

