

**JAMES A. GARFIELD LOCAL SCHOOL DISTRICT  
EMERGENCY MEDICAL AUTHORIZATION**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ School Attending \_\_\_\_\_  
\_\_\_\_\_ Grade \_\_\_\_\_

**PART I: TO GRANT CONSENT**

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

**Residential Parent or Guardian:**

Mother \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Father \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Other Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Name of a relative or childcare provider \_\_\_\_\_

Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_

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

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

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

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

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

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for any treatment deemed necessary by the above mentioned physicians.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

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

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

**PART II: CONSENT TO SHARE/DISSEMINATE INFORMATION**

I give consent for the school medical personnel to share appropriate medical concerns with my child's teacher and other staff as necessary.

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

**PART III: REFUSAL TO CONSENT:**

I do NOT give 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:

\_\_\_\_\_

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