

2009 - 2010
The Autism Academy of Learning
EMERGENCY MEDICAL AUTHORIZATION

Student Name: _____ SS#: _____
Address: _____ Grade: _____
City/State/Zip: _____ DOB: _____
Telephone: _____ Age: _____

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.

Emergency contact/guardian needs to have access to transportation.

Residential Parent/Guardian:

Mother's Name _____ Daytime Phone _____
Father's Name _____ Daytime Phone _____
Other's Name _____ Daytime Phone _____

Name(s) of Relative/Neighbor or Childcare Provider for Emergency Contact

Name _____ Relationship _____ Daytime Phone _____
Name _____ Relationship _____ Daytime Phone _____
Name _____ Relationship _____ Daytime Phone _____

TO GRANT CONSENT

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

Physician _____ Phone _____
Dentist _____ Phone _____
Medical Specialist _____ Phone _____
Local Hospital _____ ER Phone _____

List all medications student is taking _____
Allergies: _____
Food: _____
Drugs: _____

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 physician, 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.

Facts concerning the child's medical history including any physical impairments to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____