

Check here if you do not want to receive general information via e-mail

LAKOTA SCHOOL DISTRICT 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 school authority, when parent or guardians cannot be reached.

Please use Blue or Black ink.

Student Address _____ Student Name _____ Sex _____
Zip _____ School _____ M / F

Home Phone # _____ Grade _____ Date of Birth _____ Home Room # _____

Father's Name _____ Work Phone _____
Address (if different than student) _____ Home Phone _____
E-mail address _____ Cell/Pgr _____
Step Mothers Name _____ Work Number _____

Mother's Name _____ Work Phone _____
Address (if different than student) _____ Home Phone _____
E-mail address _____ Cell / Pgr _____
Step Father's Name _____ Work Number _____

Guardian's Name _____ Work Phone _____
(if other than parents)
E-mail address _____ Cell/Pgr _____

Person(s) who may be notified and to whom your child may be released if school cannot reach you.

1. _____ Relationship _____ Phone _____
2. _____ Relationship _____ Phone _____
3. _____ Relationship _____ Phone _____

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

The School Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called _____ Phone _____
Dentist to be called _____ Phone _____
Preferred local hospital _____

PART 1-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 above named doctor 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 opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date _____ Signature of Parent / Guardian _____

PART 2- TO REFUSE 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: _____

Date _____ Signature of Parent /Guardian _____

Lakota Local School District Form 6510B

Cross-Reference: Board Policy 6510

Adopted 08/23/2004