EMERGENCY MEDICAL AUTHORIZATION
FOR ALL SCHOOL-RELATED ACTIVITIES

STUDENT NAME:______________________________ SCHOOL: **TURPIN HIGH SCHOOL**

ADDRESS:______________________________ TELEPHONE:__________

TEACHER/HOMEROOM:______________________________ GRADE:__________

DATE OF BIRTH:______________________________ SPORT:__________

ATHLETICS – CHECK ALL THAT APPLY: FALL SPORT__________ WINTER SPORT__________ SPRING SPORT__________

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

RESIDENTIAL PARENT OR GUARDIAN:______________________________

MOTHER'S NAME:______________________________ DAYTIME PHONE:__________
E-MAIL ADDRESS:______________________________ CELL PHONE:__________

FATHER'S NAME:______________________________ DAYTIME PHONE:__________
E-MAIL ADDRESS:______________________________ CELL PHONE:__________

OTHER FAMILY NAME:______________________________ DAYTIME PHONE:__________

PERSON OTHER THAN PARENT MY CHILD MAY BE RELEASED TO IN THE CASE OF A MEDICAL OR OTHER EMERGENCY:

NAME:____________________ PHONE #:__________ CELL #:__________

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT:

DOCTOR TO BE CALLED:______________________________ PHONE #:__________

DENTIST TO BE CALLED:______________________________ PHONE #:__________

MEDICAL SPECIALIST:______________________________ PHONE #:__________

HEALTH INSURANCE CO.:______________________________ POLICY #:__________
(PLEASE ATTACH A COPY OF HEALTH INSURANCE CARD) EMPLOYER PROVIDING:__________

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. Preferred local hospital: ______________________________.
(Name of Hospital) (Telephone No.)

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: ______________________________
______________________________.

Date:__________ Signature of parent/guardian______________________________

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 school authorities to take no action or to:______________________________

Date:__________ Signature of parent/guardian______________________________

Address:______________________________