GARAWAY LOCAL SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION FORM

School Building		Student Name	
Grade	Date of Birth	Street Address	
Primary Contact Number ( )		Mailing Address (P.O. Box)	
E-mail Address		City	ZIP

RESIDENTIAL PARENT OR GUARDIAN (Please specify if you are a step-parent or grandparent.)
☐ **Married** ☐ **Divorced** ☐ **Separated**

Mother's Name	**Father's Name**	**Guardian's Name**
Home Phone ( )	Home Phone ( )	Home Phone ( )
Cell Phone ( )	Cell Phone ( )	Cell Phone ( )
Work Phone ( )	Work Phone ( )	Work Phone ( )

Step Mother's Name	**Step Father's Name**	**Emergency Contact**
Home Phone ( )	Home Phone ( )	**Relationship to Child**
Cell Phone ( )	Cell Phone ( )	Phone ( )
Work Phone ( )	Work Phone ( )	Phone ( )

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical care provider to be called:

Physician	City	Phone ( )
Dentist	City	Phone ( )
Medical Specialist	City	Phone ( )

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 doctors, 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:

Medication (Continuous):
Allergies:
Physical Impairments:

Signature of Parent/Guardian ____**Date**________________

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 the following action:____________________________________

Signature of Parent/Guardian ____**Date**________________