

REVERSE SIDE OF FORM MUST BE SIGNED AND NOTARIZED
EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable Parents/Guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority if parents cannot be reached.

TO GRANT CONSENT

In the event reasonable attempts to contact me _____ at (phone) _____ or (other parent/guardian) _____ at (phone) _____ have been unsuccessful, I give my consent for administration of any treatment deemed necessary and by another physician or dentist if the designated practitioner is not available. I also consent for the transfer of my child to (hospital) _____ or any hospital reasonably accessible by ambulance. 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, medication being taken, and any physical impairment to which a physician should be alerted:

Parent/Guardian Signature



Notarization

State of Florida County of _____
Sworn to & subscribed before me this _____ day of _____ 20__

Notary Public Signature

