

EMERGENCY MEDICAL AUTHORIZATION FORM

St. Mark Lutheran School

| | |
|------------------|----------------|
| Student Name | Grade |
| Address | Home Phone |
| City, State, Zip | Email (parent) |

Purpose - To enable parents and guardian 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.

| Residential Parent or Guardian | | |
|--------------------------------|-----------|------------|
| Mother's Name | Day Phone | Cell Phone |
| Father's Name | Day Phone | Cell Phone |
| Other Name | Day Phone | Cell Phone |

| Relative or Childcare Provider | |
|--------------------------------|---------------|
| Name | Relationship |
| Address | Daytime Phone |
| City, State, Zip | |

COMPLETE PART I OR PART II BELOW

PART I: TO GRANT CONSENT

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

| | |
|--------------------|-------|
| Physician | Phone |
| Dentist | Phone |
| Medical Specialist | Phone |
| Local Hospital | Phone |

In the event reasonable attempts to contact me have been unsuccessful, I, hereby, give my consent for the administration of treatment deemed necessary by the above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to the above named hospital or 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 before the surgery is performed. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted are as follows:

| | |
|------------------------------|------|
| Signature of Parent/Guardian | Date |
| Address, City, State, Zip | |

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 regarding emergency treatment, I wish the school authorities to take the following action:

| | |
|------------------------------|------|
| Signature of Parent/Guardian | Date |
| Address, City, State, Zip | |