☐**Check if you do not want to receive general information via email.**

# 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**

**Sex** M or F **Student ID**_____ **Student Name**_____

**Student Address**_____ Zip _____

Home Phone _____ Grade_____ Date of Birth_____

School _____ Homeroom#_____

**Father's Name** _____ Home Phone_____ Work Phone _____

Address (if different than student)_____

E-mail address _____ Cell/Pgr _____

**Mother's Name** _____ Home Phone _____Work Phone_____

Address (if different than student)_____

E-mail address_____ Cell/Pgr_____

**Guardian's Name**_____ Home Phone_____ 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_____

**Allergies and/or specific health consideration**_____

**Medication taken by student on a daily or frequent basis**_____

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

Doctor to be called_____ Phone number_____

Dentist to be called_____ Phone number_____

Preferred local hospital_____ Phone number_____

**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** **Revised: 8/9/2010**