EMERGENCY MEDICAL & SURGICAL TREATMENT AUTHORIZATION

Dear Parents:

It is the firm hope that the authorization granted on this form will never have to be used. For the safety of the children, however, sound medical practice calls for such authorization. In emergency situations where, for some reason, the parent of the child cannot be contacted immediately, this form may be extremely important. The authorization granted by this form will be used only when absolutely necessary and only after every attempt has been made to contact the parents or other emergency contacts. Doctors and hospitals may refuse to give any treatment, regardless of how minor, unless they have authorization from the parents.

Please sign below

To Whom It May Concern:

I understand that in the event of an emergency where I, or my emergency contacts cannot be reached, I hereby give permission to the physician or hospital selected by the school to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my children.

_____ _____
Name of Child Grade

_____ _____
Name of Child Grade

_____ _____
Name of Child Grade

_____ _____
Name of Child Grade

_____ _____
Name of Child Grade

_____ _____ _____
Date Parent Name Signature

PLEASE RETURN THIS FORM BY THE FIRST DAY OF SCHOOL