STUDENT NAME_____
(Please print) Last First

The School of Strings
EMERGENCY MEDICAL AUTHORIZATION FORM

Date of Birth_____ Home Phone_____

School_____ Address_____

School Year_____ Grade_____ City_____ Zip_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under our care when parents or guardians cannot be reached. This information will be shared, as necessary, with The School of Strings teachers and administrative staff.

Residential Parent or Guardian

Mother's Name_____ Best Contact Number_____

Father's Name_____ Best Contact Number_____

Emergency Contacts: 1. _____ Best Contact Number_____

2. _____ Best Contact Number_____

Please identify any health concerns that we should be aware of:

Allergies: No_____ Yes_____ Specify_____

Epi-pen: No_____ Yes_____ ***If yes, Epi-pen Authorization Form must be completed.***

Asthma: No_____ Yes_____ ***If yes, Inhaler Authorization Form must be completed.***

Seizures: No_____ Yes_____ Emergency Seizure Medications? _____
Name of medications

Diabetes: No_____ Yes_____ Emergency Diabetic Medication? _____
Name of medications

Does your child take any medication regularly? ___No ___Yes Specify_____
(medication, amount taken, how often)

Will your child take medication while at the School of Strings? ___No ___Yes ***(If yes, Permission to Dispense Medication Form must be completed.)***

Are there any other medical conditions that we should be aware of? _____

_____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor_____Phone_____

Dentist_____Phone_____

Medical Specialist_____Phone_____

Local Hospital/Emergency Room 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 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 the two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____
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 of strings teachers to take the following action:

_____

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_____
Signature of Parent/Guardian Date