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? ____________________________________
Diabetes: No_____ Yes_____ Emergency Diabetic Medication? _________________________________

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.

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:

______________________________________________________________
______________________________________________________________
______________________________________________________________

Signature of Parent/Guardian Date