

**AUTHORIZATION TO SCHOOL  
EMERGENCY MEDICAL TREATMENT FOR MINOR**

*Authorization*

I, \_\_\_\_\_, of \_\_\_\_\_  
(address), am the \_\_\_\_\_ (father/mother/legal guardian) of  
\_\_\_\_\_, a minor, of \_\_\_\_\_  
(address), who attends \_\_\_\_\_ (name of school),  
located at \_\_\_\_\_ (address).

In the event all reasonable attempts by authorized school personnel to contact me at  
\_\_\_\_\_ (phone number) or to contact \_\_\_\_\_  
(other parent/guardian) at \_\_\_\_\_ (phone number) have been unsuccessful, I  
give my consent for:

1. The administration of any treatment deemed necessary by \_\_\_\_\_  
(preferred physician) or \_\_\_\_\_ (preferred dentist), or, in the  
event the appropriate preferred practitioner is not available, by another licensed  
physician or dentist; and
2. The transfer of the minor to \_\_\_\_\_ (preferred hospital) or any  
hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other  
licensed physicians concurring in the necessity for such surgery are obtained prior to the  
performance of such surgery.

The following information is needed by any hospital or practitioner not having access to  
the minor's medical history:

Allergies: \_\_\_\_\_

Medication being taken: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Physical impairments: \_\_\_\_\_

Other pertinent facts to which physician should be alerted:  
\_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)