SEYMOUR COMMUNITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION

School Name:_____

Student Name:_____

Grade_____ Address_____

Parent / Guardian _____ Phone_____

CONSENT TO GRANT TREATMENT FORM
2017-2018 SCHOOL YEAR

In the event reasonable attempts to contact me at _____ (home/work/cell phone) or _____ (emergency name) at _____ (emergency phone) have been unsuccessful, I hereby give my consent for:

1.) The administration of any treatment deemed necessary by a licensed physician or dentist.
2.) The transfer of my child to _____ (hospital of choice) or any hospital reasonably accessible.

This does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentist concur with the necessity for each surgery are obtained prior to the performance of such surgery.

This consent does not extend itself to any of the following procedures

1._____
2._____
3._____

Facts concerning the allergies, medications, or physical impairment for the above named student include:

_____
_____
_____
_____

Student/Athlete signature:_____ Birthdate:_____
Parent/Guardian signature:_____
Witness:_____ Date:_____