SEYMOUR COMMUNITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

School Name:____

Student Name:____

Grade________ Address____

Parent / Guardian ____________________________________ Phone____________

CONSENT TO GRANT TREATMENT FORM
2016-2017 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:___________________