



EMERGENCY MEDICAL AUTHORIZATION

Child's Name _____ District of Residence _____
Address _____ Phone _____

Purpose - To enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while S.A.I.L. is acting as service provider to the child, when parent(s) or guardian(s) cannot be reached.

Residential Parent(s)/Guardian(s):

| | |
|---|----------------------|
| Mother's Name _____ | Daytime Phone: _____ |
| Father's Name _____ | Daytime Phone: _____ |
| Other's Name _____ | Daytime Phone: _____ |
| Name of Relative or Childcare Provider: _____ | Relationship: _____ |
| Address _____ | Daytime Phone: _____ |

(PART I OR PART 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: _____ |
| Med. Specialist _____ | Phone: _____ |
| Local Hospital _____ | ER Phone: _____ |

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (2) the administration of any treatment deemed necessary by above -named doctor, or in the event the designated practitioner is not available, by another licensed physician or dentist, concurring in the necessity for transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date _____ Signature of Parent/Guardian _____
Address _____

(DO NOT COMPLETE PART II IF COMPLETED PART I) - 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 want S.A.I.L. authorities take the following action:

Date _____ Signature of Parent/Guardian _____
Address _____