Alexandria Montessori
School

Emergency Medical Authorization 2023-2024

Student's Name _____ Birth Date _____

Address _____ Phone _____

Purpose: to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

CONSENT FORM

In the event that reasonable attempts to contact me (name)_____at (phone #)_____or (other name) _____at (phone #)__ _____ have been unsuccessful, I _____hereby give my consent for **(1)** the administration of any treatment deemed necessary by: preferred physician Dr. _____at phone #_____or preferred dentist Dr. _____at phone #_____or, in the event that the preferred practitioner is not available, by another licensed physician or dentist; and **(2)** the transfer of the child to _____or any other hospital reasonably accessible.
(preferred medical facility)

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICANS 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:

Allergies: _____ Date of Last Tetanus Immunization: _____

Current Medications: _____

Physical Impairments: _____

Other Medical History: _____
(include anything a physician or dentist should be aware of)

Insurance Company: _____ Policy # _____

Parent/Guardian Signature _____ Date _____

Address: _____