ORIGINAL

THE SEVEN HILLS SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Name (First, Middle, Last) | Preferred | Date of Birth | Grade | Homeroom (if applicable)

Address | City, State, Zip | Telephone | TSHS ID #

Parent/Guardian 1 Name | Home Phone | Cell Phone/Pager | Business Telephone

Parent/Guardian 2 Name | Home Phone | Cell Phone/Pager | Business Telephone

Two emergency contacts other than the parents to whom we may release your child:

Emergency Contact 1 | Area Code & Phone | Address | Relationship

Emergency Contact 2 | Area Code & Phone | Address | Relationship

Preferred Doctor | Area Code & Phone | Address

Preferred Dentist | Area Code & Phone | Address

This consent form authorizes emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I or Part II must be completed.

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact _____ or _____ at the above phone numbers have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by (Preferred Dr.) _____ (phone) _____ or (Preferred dentist) _____ phone _____ or by any other licensed physician or dentist if the designated practitioner is not available, and (2) the transfer of the child to (preferred hospital) _____ or any hospital reasonably accessible.
This document authorizes major surgery when the opinions of 2 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed. Please list all relative facts concerning your child's medical history, including: allergies; prescribed medications;and physical impairments to which a physician should be alerted.

Medications	Special Needs and Conditions	Allergies

Date | **Signature of Parent/Guardian Required** | **Date of last tetanus**

Insurance Company | Policy Number | Policy Holder

Signature of Parent/Guardian Required

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART I I (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 wish the school authorities to take no action or to:

Date | Signature of Parent