

**HS@AKIVA Emergency Medical Authorization**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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.

Please describe any special learning concerns or considerations which @Akiva faculty should be made aware. \_\_\_\_\_

**Part I or II Must Be Completed  
Part I Granting Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone Number \_\_\_\_\_

Local Hospital \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the 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, medication being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Do Not Complete Part II if you 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 wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_