THE FRANKLIN SCHOOL OF INNOVATION
An EL Education School

Emergency Medical Authorization Form

This must be completed for every student prior to 8/21/2019

STUDENT NAME:_____ DOB_____

2019-2020 Grade:_____

Does your student have any **life-threatening allergies** that will require medication on file at the school? If Not Applicable, please write N/A. If so, please list them, along with the medication required. Please use back of page if more space is needed.

1. _____
2. _____

If your student requires medication on file at school for **non-life-threatening** medical conditions, please list them along with the medication required.

1. _____
2. _____

Did your student suffer a concussion during the 2018-2019 School Year? YES or NO

In the event of an emergency with your student, please list in order who we should contact and the best number to reach them.

NAME **PHONE NUMBER**

1. _____
2. _____

CONSENT: 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 the appropriate medical professional; 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.

Guardian Signature for Consent_____ Date_____

REFUSAL TO CONSENT: ***I do NOT give 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:

_____

_____

By signing this form, I agree that I have read and understand the above information regarding my student, with regards to a medical emergency.

Signature_____ **Date**_____