THE FRANKLIN SCHOOL OF INNOVATION
An EL Education School

Emergency Medical Authorization Form

Student Name: ____ Birth Date: ________________________ Grade: ________

Address: ____ Student Lives With: _____________________________

City/Zip Code:____Primary Phone #: _________________________

PARENT/GUARDIAN(S) AND EMERGENCY CONTACTS

Order	Name	Relationship	Primary Phone	Secondary Phone
______	__________________________________	_________________	(____)____________	(____)____________
______	__________________________________	_________________	(____)____________	(____)____________
______	__________________________________	_________________	(____)____________	(____)____________

Please indicate if your student has any of the following:

Allergies (please list): ____

Medications* (please list): ____

Inhalers* (please list): ____

Other medical conditions or concerns to which medical Personnel should be alerted ____

____

* Use and/or possession of any medications, whether prescribed or not, requires the appropriate documentation to be completed and on file with the school.

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Physician ____________________________________ **Phone:**_________________________

Dentist ____________________________________ **Phone:**_________________________

Medical Specialist ____________________________________ **Phone:**_________________________

Hospital ____________________________________ **Phone:**_________________________

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.

Initials of Parent/Guardian for Grant for Consent Date___________________

PART II: 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:

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Initials of Parent/Guardian for Refusal to Consent Date___________________