



ISAK Sunday School

Emergency Medical Authorization

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

In case of your child's illness, we call the numbers you give us in the order listed. **Four numbers** help us in cases of emergency.

PARENTS OR GURDIAN

1. Mother Name _____ Mobile Number _____

2. Father Name _____ Mobile Number _____

Address _____

Number and Street

City

State

Zip

OTHER RELATIVES OR RESPONSIBLE PARTIES

1. Name _____ Relationship _____ Mobile Number _____

2. Name _____ Relationship _____ Mobile Number _____

3.

PLEASE COMPLETE PART I **OR** II – NOT BOTH

PART I- TO GRANT CONSENT

In the event reasonable attempts to contact me or the numbers listed above have been unsuccessful, I hereby give consent for calling **911** and transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity such surgery, are obtained prior to the performance of such surgery.

Date _____ Parent or Guardian Signature _____

PART II-DO NOT GRANT 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 will request the school authorities to take no action or to:

Date _____ Parent or Guardian Signature _____

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Facts concerning the child's medical history including allergies and medications need to be taken during school time

Child Name _____ **Date of Birth** _____

Allergies: _____

Medications: _____

Child Name _____ **Date of Birth** _____

Allergies: _____

Medications: _____

Child Name _____ **Date of Birth** _____

Allergies: _____

Medications: _____

Child Name _____ **Date of Birth** _____

Allergies: _____

Medications: _____