EMERGENCY MEDICAL AUTHORIZATION

Urbana School District #116
205 North Race Street, P.O. Box 3039
Urbana, Illinois 61801-2669

Please complete the EMERGENCY MEDICAL AUTHORIZATION form. This form must be returned to each school office. If this information is to be changed during the school year, please send a written note to the principal of your child's school requesting an update. Please be sure to list any health problems or conditions on the back of the attached form. *Please Note: Hospitals will not treat a student under 18 years of age without written parent/guardian permission. (4/98)

_____ _____
Student Name Address

_____ _____
School Attending Grade

In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give consent for: (1) the administration of any treatment deemed necessary by a licensed physician; and (2) the transfer of the child to any hospital reasonably accessible. I/We understand that I/we will be responsible for any charges incurred for medical treatment given my child pursuant to this authorization.

I/We understand that it is in the best interest for the welfare of my child that the Urbana School District #116 be given this authorization for emergency situations. Therefore, we agree to hold the District, its representatives and employees, harmless from any and all claims made against it, including any medical charges as the result of my child receiving medical treatment pursuant to this authorization.

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

The Emergency Medical Authorization shall continue in full force and effect until the Urbana School District #116 is advised in writing of any change desired by the undersigned.

Date_____ Signature of Parent/Guardian _____

Parent/Guardian Name _____

Home Phone _____Work Phone _____Cell Phone _____

Other Emergency Phone Numbers _____

Preferred Physician _____ Phone_ _____

Preferred Hospital _____

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/Guardian _____

-OVER-

STUDENT NAME: _____

Please indicate any health problems or special conditions such as allergies, medication being taken and any physical impairments which should be part of this student's school records.