Re-Education Services, Inc.

EMERGENCY MEDICAL AUTHORIZATION

_____ _____
(Student Name) (Grade)

_____
(Address)

_____
(Phone Number)

Purpose – To enable parent to authorize emergency treatment for children who become ill or injured while under educational facility authority, when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART 1 (TO GRANT REQUEST)

If the event reasonable attempts to contact me at _____, or _____
(Daytime phone number)

_____, at _____, or _____
(Other parent) (Daytime phone number) (Relative or childcare provider)

_____, or _____ at _____
(Daytime phone number) (Other name) (Daytime phone number)

Medicaid Identification Number: _____

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Local Hospital _____ Phone _____

This authorization does not cover major surgery unless the medical opinion of two other physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____ _____
(Date) (Signature of residential parent or custodian)

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 educational facility authorities take no action or to:

_____

_____ _____
(Date) (Signature of residential parent or custodian)