

SALT LAKE LUTHERAN HIGH SCHOOL

4020 SOUTH 900 EAST
SALT LAKE CITY, UT 84124
801.266.6676

EMERGENCY MEDICAL AUTHORIZATION

Purpose: For parent/guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reach.

Student Name _____ **DOB** _____ **Blood Type** _____

Address _____ **City/State/Zip** _____

Parent/Guardian _____ **Home Phone #** _____ **Alternate #** _____

Alternate Contact _____ **Home Phone #** _____ **Alternate #** _____

Physician's Name _____ **Phone #** _____

Dentist name _____ **Phone #** _____

Hospital Name _____ **Location** _____

Insurance Carrier _____ **Policy #** _____

Allergies of any type:

Please list restrictions/physical impairments:

Current or recent Medical Problems:

List Medications Student is taking and amount

Student has permission to take Tylenol and/or Ibuprofen: Yes ___ No ___ **Amount**

Does Student wear glasses or contacts: Yes ___ No ___

(over)

Authorization for Treatment: In the event reasonable attempts to contact me, (parent/guardian) are unsuccessful, I (we), the undersigned parent/legal guardians, do authorize any hospital, clinic, or licensed physician to treat my/our child and administer any x-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital, clinic or office.

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school's athletic trainer or coach to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

Signature of Parent/Guardian

Date

(Do not complete if you signed Authorization for Treatment. above)

Refusal to Consent: I, _____ (Parent/Guardian) **DO NOT GIVE** consent for emergency medical treatment for my/our child in the event of any illness or injury requiring emergency medical treatment. I wish the school authorities to take no action and to do the following:

Signature of Parent/Guardian

Date

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