Diamond Star Academy
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EMERGENCY MEDICAL AUTHORIZATION

Student Name _____

PURPOSE- To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I (To Grant Consent)

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Telephone (____) _____

Dentist _____ Telephone (____) _____

Medical Specialist _____ Telephone (____) _____

Local Hospital _____ Telephone (____) _____

Type of Health Insurance: HMO ____ Medicaid ____ No health insurance ____ other ____

If the student is covered by Medicaid, provide the case ID # number: _____

Read and check:

____ I understand that for those school health and health related services that the Medicaid-eligible student may be receiving – including but not limited to: vision and hearing screenings, nursing services, speech therapy, occupational and/or physical therapy – the school district has the right to receive partial reimbursement from Medicaid for those services rendered.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before the surgery is performed.

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

_____

_____

DSA will attempt to reach the parent/legal guardian or one of the people listed as an emergency contact but if none of these people can be reached, DSA personnel have my permission to use discretion in securing medial aid in an emergency. ***IT IS UNDERSTOOD THAT NEITHER DSA NOR THE PERSON RESPONSIBLE FOR OBTAINING THIS MEDICAL AID WILL BE RESPONSIBLE FOR THE EXPENSE INCURRED.***

_____

Signature of Guardian Date

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (Refusal of 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:

_____

Signature of Guardian Date