Student Name _____ _____ Placement Date: _____

IMPACT

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that a parent/legal guardian cannot be reached, this completed form enables a parent/legal guardian to authorize emergency treatment for children/ adolescents needing professional medical attention for illness or injury while at the Impact Academy during program hours of operation.

TO GRANT AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

If reasonable attempts to contact me at _____ or _____ fail,
(Daytime phone number) **(Other phone number)**

please call _____**, at** _____**, or**
(Other parent or authorized adult) **(Other phone number)**

_____ **at** _____ for authorization to
(Other parent or authorized adult) **(Other phone number)**

treat my child with the medical attention necessary to treat his/her condition.

In the case of a medical emergency, I give my formal consent for the following medical providers and local hospital to be contacted and/or utilized for treatment:

Doctor _____ **Phone** _____

Local Hospital _____**Phone** _____

This consent does **not** cover major surgery, unless the medical opinions of two physicians, in agreement about the necessity of surgery, are acquired before surgery commences.

Please list any current allergies, medications, and/or any physical conditions:

_____

_____

X_____ _____
(Print and Sign name of Parent/Legal Guardian) **(Date)**

TO REFUSE CONSENT FOR EMERGENCY MEDICAL ATTENTION:

I do NOT give consent for emergency medical attention for my child. In the event of illness or injury requiring emergency medical treatment, I request that Impact Academy do the following:

_____

_____

_____ _____
(Print and Sign name of Parent/Legal Guardian) **(Date)**