

# Lexington Montessori School

## Emergency Medical Authorization

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become injured or ill while under school authority, when parents or guardians cannot be reached.

**Please print all information legibly**

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Mother:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Father:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

In the event that reasonable attempts to contact me have been unsuccessful, I give my consent for:

1) the administration of any treatment deemed necessary, by

Preferred Physician: Dr. \_\_\_\_\_ at \_\_\_\_\_ phone \_\_\_\_\_

Dentist/Orthodontist: Dr. \_\_\_\_\_ at \_\_\_\_\_ phone \_\_\_\_\_

or

2) in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to \_\_\_\_\_  
(preferred hospital) or any hospital reasonable in accessibility.

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_