EMERGENCY MEDICAL AUTHORIZATION

To enable parents or guardians to authorize the provision of emergency medical treatment for individuals who become ill or injured while under Sandy Cay, Inc. / The Bryan Center authority, when parents or guardians cannot be reached.

Child's Name:_____ DOB:_____ Age:_____ Grade:_____Date:_____

Diagnosis/Conditions:_____

Medications / Dosage:_____

Custodial parent(s)/guardian:_____

Mother's Name/Address:_____

Home Phone:_____ Cell:_____ E-Mail:_____

Business:_____ Phone:_____ E-Mail:_____

Father's Name/Address:_____

Home Phone:_____ Cell:_____ E-Mail:_____

Business:_____ Phone:_____ E-Mail:_____

Siblings/Ages:_____

In Case of Emergency, Contact:

Name:_____Phone:_____Cell:_____
Address:_____Relationship:_____

Alternate Emergency Contacts:

Name_____Phone:_____Cell:_____
Address:_____Relationship:_____

Name:_____Phone:_____Cell:_____
Address:_____Relationship:_____

Part I - To Grant Consent: I hereby give consent for the following medical care providers and local hospital

Physician's name: _____ Address:_____ Phone: _____
Dentist's name:_____ Address:_____ Phone: _____
Medical Specialist:_____ Address:_____ Phone: _____
Local Hospital:_____ Address:_____ Phone: _____
Medical Insurance Co:_____ Policy Holder:_____
Allergies (including to medication):_____
Other information:_____

In the event a reasonable attempt to contact me has been unsuccessful, I hereby give consent for transportation, release of client records and the administration of any treatment and/or medication deemed necessary by the above named doctor or another licensed physician or dentist or emergency personnel at the above hospital, on site or at any hospital/clinic/facility reasonably accessible. Treatment authorization also includes x-rays, surgery and hospitalization.

Signature of client, parent or legal guardian: _____ Date:_____

Part II – Refusal to Consent: I do **NOT** give consent for emergency medical treatment for_____. In the event of illness or injury requiring emergency treatment, I wish SCI / The Bryan Center to take the following action:

_____

_____

Signature of client, parent or legal guardian: _____ Date:_____