

# Norma Johnson Center

## EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents/guardians to **AUTHORIZE EMERGENCY TREATMENT** for children who become ill or injured while under the authority of the Norma Johnson Center, when parents cannot be reached.

**Please print.**

Participants Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_

The legal guardian(s) for this participant is/are \_\_\_\_\_  
 List the names, relationship to the participant, and phone numbers of those people the Norma Johnson Center should call in the event of accident or illness. This list should include the parent(s)/legal guardian(s) if they are to be contacted, and should be in the order of calling preference.

Name	Relationship	Home Phone	Work Phone	Cell Phone/Pager
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*I understand that my child may be released to anyone on the above list if he/she becomes ill or injured and must leave the Norma Johnson Center's program.*

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Date

**Medical Problems/Allergies/Special Needs:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Bee or Insect Sting |
| <input type="checkbox"/> Visually or Hearing Impaired | <input type="checkbox"/> Medication or Food Allergy | <input type="checkbox"/> Orthopedic          |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Other                      |  |

Please provide detailed information regarding any above marked areas: \_\_\_\_\_  
 \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital (1<sup>st</sup> choice) \_\_\_\_\_ (2<sup>nd</sup> choice) \_\_\_\_\_

**Please complete EITHER Part I or Part II below:**

**Part I: Grant Consent**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the previously-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and, (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Date

**Part II: Refusal to consent (DO NOT COMPLETE IF YOU COMPLETED PART I).**

**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 Norma Johnson Center staff to take the following action: **(MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)**

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Date