AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The purpose of this form is to make it possible for parents and guardians to authorize the provision of emergency medical treatment for children who become ill or are injured while under school authority and their parents or guardians cannot be reached. Such consent is helpful in providing prompt treatment when all reasonable attempts to reach parents or guardians have failed. You can authorize such emergency treatment for your child by completing this form. This authorization does not cover major surgery unless it is deemed necessary by a physician to do so before contact with parents or guardians can be completed.

APPROVAL

I _____ of _____, am the _____
Name of parent/guardian Address Mother, Father, Parent, Guardian

of _____, a minor, of _____ who attends
Child's name Child's address

The Bala House Montessori School, Conshohocken State Road, Bala Cynwyd, PA

I hereby **give my consent** for the administration of any emergency medical treatment deemed necessary

by the hospital attending physicians, in the event that all reasonable attempts to contact me at

_____ or _____ at _____
Phone # Other parent/ guardian Phone #

have been unsuccessful.

_____ _____
Signature of parent/guardian Date

DISAPPROVAL

I _____ of _____, am the _____
Name of parent/guardian Address Mother, Father, Parent, Guardian

of _____, a minor, of _____ who attends
Child's name Child's address

The Bala House Montessori School, Conshohocken State Road, Bala Cynwyd, PA

I **do not** give my consent for emergency medical treatment of my child. In the event of a medical emergency, I wish the school authorities to do the following:

_____

_____

_____

_____ _____
Signature of parent/guardian Date