



MDQ ACADEMY
 1725 Brentwood Road, Building 2
 Brentwood, NY 11717
 Phone: (631) 665-5036
 Fax: (631) 521-7718

Emergency Medical Authorization Form 2019-2020

Please fill out this form and return it to your child's school.

Student Name: _____ Grade: _____ Date of Birth: _____

Student's Address: _____

City: _____ State: _____ Zip: _____

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

Residential Parent or Guardian Mother's Name:		Daytime Phone:
Residential Parent or Guardian Father's Name:		Daytime Phone:
Name of Relative or Emergency Contact:	Relationship	Daytime Phone:

PART I or II MUST BE COMPLETED

PART I: TO 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 a licensed physician or dentist; and (2) the transfer of my 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 my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Parent/Guardian Name:	Parent/Guardian Signature:	Date:
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