SENECA MENTORING YOUTH LINKS

EMERGENCY MEDICAL AUTHORIZATION

Name _________________ DOB ________ Parent/Guardian ____________________

Address ____

Phone (home) ________________________ (cell/work) _________________________

PURPOSE- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the authority of a Mentor when Parents or Guardians cannot be reached.

(1 or 2 must be completed)

PART 1 TO GRANT CONSENT

In the event reasonable attempts to contact me at ________________ (phone number) or (other parent or guardian) at ________________ have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr.________________ (preferred physician or Dr.________________(preferred dentist), or, in the event 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 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.

This authorization shall be valid during the period said child is officially affiliated with SMYL, unless revoked in writing by the undersigned.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be catered:

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______________________________________ ______________________________

Signature of Parent/Guardian Date

PART 2 REFUSAL TO CONSENT (DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the Mentor to take no action or to:

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______________________________________ ______________________________

Signature of Parent/Guardian Date

IN NON-MEDICAL EMERGENCY SITUATIONS IF THE PARENT CANNOT BE REACHED CONTACT THE FOLLOWING RELATIVE, FRIEND OR NEIGHBOR.

Name: ______________________________ at Phone ____________________________

Name: ______________________________ at Phone ____________________________