Morgan County Schools Health Services

Permission to Treat—Staff

PURPOSE: To enable Morgan County Schools' employees to authorize emergency treatment should they become ill or injured.

Employee's Name: ____ Birth date: ______________________

Emergency Contacts:

Name	Phone Number	Relationship

In the event, reasonable attempts to contact listed authorized family members have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by

Dr. ____________________________ or Dr. -__________________________________

(preferred physician (preferred dentist)

Or

in the event the designated preferred practioner is not available, by another licensed physician or dentist.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained BEFORE the surgery IS PERFORMED. Facts concerning the personal medical history including allergies, medication being taken and any physical impairment to which a physician should be alerted include:

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In the event physicians, other persons named cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid employee.

I will not hold the school district financially responsible for the emergency care and/or transportation.

Employee Signature: ____ Date: _________________________

Address ____ Phone: _________________________

City, State: ____ Zip code: _________________________

This form must be signed and notarized. This form is valid during the duration of employment or until the employee states in writing that the form is no longer valid.

State of Tennessee County of ______________ Sworn before me this ________ day of ___________________

NOTARY PUBLIC ____

MY COMMISSION EXPIRES: ____

*** Please attach a copy of your insurance card.