EMERGENCY MEDICAL AUTHORIZATION

School _____ Grade _____ Teacher _____

Student Name _____ D.O.B. _____

Address _____ City _____ Ohio Zip _____

Home Phone _____

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 - **Please include ALL parent/guardian daytime phone numbers below (i.e. cell/pager).**

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Child Care Provider _____ Relationship _____

Address _____ Phone _____

PART I OR II MUST BE COMPLETED

PART I ~ TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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 above-named doctor, or, in the event the disignated 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 any 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 impairments to which a a physician should be alerted:

_____

_____

Date _____ Signature of Parent/Guardian _____

Address _____

PART II ~ REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU HAVE 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 school authorities to take the following action:

_____

_____

Date _____ Signature of Parent/Guardian _____

Address _____