ESC of the WESTERN RESERVE
Inspiring Learning Through Innovation

Educational Service Center of the Western Reserve

Emergency Medical Contacts and Transportation Authorization

TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

The purpose of this form is 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.

Student Name_____ Date of Birth_____ Home Phone_____
(Last) (First) (Area Code)

Parent Name(s) _____

Address _____ City_____ Zip Code_____

In situations where the parent cannot be reached the student may be released to the following:

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

Part I - To Grant Consent

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

Doctor:_____Phone:_____Dentist:_____Phone:_____

Medical Specialist:_____ Phone:_____Local Hospital:_____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 the above named doctor or, in the event the designated 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 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 impairment which a physician should be alerted**: _____

Signature of custodial/residential parent:_____ **Date**_____

Part II - DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II – REFUSAL TO CONSENT

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:_____

Signature of custodial/residential parent:_____

Address:_____ **Date**:_____