EMERGENCY MEDICAL AUTHORIZATION FORM

School (circle one): Littlest Generals Cornerstone Kean Melrose Parkview Edgewood Wooster High School

Student's Name: _____ _____ Date of Birth:_____
First Name **Last Name**

Student's Home Address:_____
Street Address **City** **State** **ZIP Code**

Student resides with (circle all that apply) Mother Father Stepparent Guardian/Other:_____

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:

Order to Call	Name	Relationship	Mobile/Cell Phone	Home Phone (Landline Only)	Daytime Work Phone

Relative or School Hours Childcare Provider:

Name	Address	Relationship	Mobile/Cell Phone	Home Phone (Landline Only)

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

Known Allergies _____

Current Medications _____

Health Concerns (diabetes, seizures, asthma, etc.) _____

_____

Physical Impairment (braces, limited mobility, prosthesis) _____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT FOR TREATMENT:

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

*Preferred Physician:*_____ Office #:_____

*Preferred Dentist:*_____ Office #:_____

*Medical Specialist:*_____ Office #:_____

*Preferred 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 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.

Parent/Guardian Signature: _____ Date:_____

OR

PART II – REFUSAL TO CONSENT DO NOT COMPLETE PART II IF YOU 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:

_____

_____

Parent/Guardian Signature: _____ Date:_____