CLSD - EMERGENCY MEDICAL AUTHORIZATION

2018-2019

15982 E. High Street, PO Box 188 Middlefield, Ohio 44062
Phone: (440)632-0261

Purpose: This form is to be completed by the parent/guardian to authorize the provision of emergency treatment for children who become ill or injured while under the school authority, when the parent(s)/guardian(s) cannot be reached. If any information below changes during the school year, you must notify the school office immediately.

Student Name:_______________________________________ School:____________________ Grade: _______
Address:__________________________ City:_____________ State:______________________ Zip: _________

Is Address Temporary ☐ Permanent ☐

Home Telephone: ( )______________________________ Student Date of Birth:_______________________

Emergency Contact #1 Name:_______________________________ Relationship:________________ Daytime Phone:____________
Cell #:__________________Email: ____________________________________ Living with Student? YES NO

Emergency Contact #2 Name:_______________________________ Relationship:________________ Daytime Phone:____________
Cell #:__________________Email: ____________________________________ Living with Student? YES NO

Emergency Contact #3 Name:_______________________________ Relationship:________________ Daytime Phone:____________
Cell #:__________________Email: ____________________________________ Living with Student? YES NO

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: _________________________ Dentist:_________________________ Specialist:_______________________
Phone: ( )_____________________ Phone: ( )_____________________ Phone: ( )_____________________
Local Hospital: ____ Phone: ( )_____________________
Medical Insurance Company: ____ Name of Insured: ________________
Facts concerning the child's medial history including allergies: ______________________________________
____
____
Medications being taken or physical impairments to which a physician should be alerted: ________________
____

In the event that 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 medical care providers, or, in the even the above-named medical care providers are 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 for dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: ____Date: _______________

PART II – REFUSAL TO GRANT 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 actions:

ACTION TO BE TAKEN: ____
____
____

Signature of Parent/Guardian: ____Date: _______________

Revised: 02/15/2018