FILE: JHC-E

EMERGENCY MEDICAL AUTHORIZATION FORM

Grade _____

School: _____ Student Name: _____ Bus Number

Last First MI

Date of Birth: _____ Address 1: _____

Social Security #: _____ Address 2: _____ Zip _____

Home Telephone: (_____) _____

(OVCTC Students only) Home High School _____

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

Mother's Name: _____ Home Phone: (_____) _____
First Last

Work Phone: (_____) _____

Father's Name: _____ Home Phone: (_____) _____
First Last

Work Phone: (_____) _____

Other's Name: _____ Home Phone: (_____) _____
First Last

Work Phone: (_____) _____

Name of Relative or Child Care Provider

Name: _____ Relationship: _____

Address: _____ Home Phone:(_____) _____

_____ Zip _____ Work Phone: (_____) _____

PART I OR II ON REVERSE MUST BE COMPLETED

(See reverse side)

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 doctors, or, in the event the designated preferred practitioner is not available, by another licensed doctor 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 doctors 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 to which a doctor should be altered:

_____

_____

Date_____Signature of Parent/Guardian _____

Address 1: _____

Address 2: _____Zip_____

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:

_____

_____

Date_____Signature of Parent/Guardian _____

Address 1: _____

Address 2: _____Zip_____

Adopted: 11/24/03

Adams County/Ohio Valley School District