Newark City Schools
Emergency Medical Authorization /Clinic Information Card

Student's Legal Name _____ **Current School**_____
Last First Middle Grade ____ Teacher _____
Date of Birth _____
Address _____ **Phone No.** _____
Student lives with _____ **Last School Attended** _____
Last Newark City School Attended _____

Father /Guardian_____**Mother / Guardian**_____
Last First **Last First**

Address _____ **Address** _____
Home Phone _____ **Home Phone No.** _____
Cell # _____ **Work No.** _____ **Cell #** _____ **Work No.** _____
Place of Employment _____ **Place of Employment** _____
Phone No. where you can be reached during the day **Phone No. where you can be reached during the day**
#_____ **#**_____

Name of Persons other than Parent/Guardian to be contacted in the case of emergency or illness:
1. Name_____ **Phone** _____ **Relationship to student** _____
2. Name_____ **Phone** _____ **Relationship to student** _____
3. Name_____ **Phone** _____ **Relationship to student** _____

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.

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:
Student's Doctor _____ **Phone** _____ **Dentist** _____ **Phone** _____

LOCAL HOSPITAL Licking Memorial Hospital **EMERGENCY ROOM PHONE** 348-4144

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.

Health Concerns _____

Current Medications _____

Allergies to Medications _____

Signature of Parent/Guardian _____ **Date** _____

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 Parent/ Guardian _____