



EMERGENCY MEDICAL AUTHORIZATION

Caregivers who complete the "Permission to treat" section of this form authorize emergency medical treatment for their student if the child becomes ill or is injured while under school authority and when parents or guardians cannot be reached.

Student's legal name: _____ Date of Birth: _____

Address: _____ Phone number: _____

Student lives with: _____ Last school attended: _____

Father/Guardian name: _____ Address: _____

Father/Guardian home phone: _____ Father/Guardian cell phone: _____

Father/Guardian place of employment: _____ Father/Guardian work phone: _____

Mother/Guardian name: _____ Address: _____

Mother/Guardian home phone: _____ Mother/Guardian cell phone: _____

Mother/Guardian place of employment: _____ Mother/Guardian work phone: _____

Name of person(s) other than parent/guardian to be contacted in case of illness or emergency:

1. Name: _____ Phone: _____ Relationship to student: _____

2. Name: _____ Phone: _____ Relationship to student: _____

Part I - Permission to Treat

I hereby consent for the following medical care providers and Licking Memorial Hospital to be called:

Student's doctor/phone number: _____

Student's dentist/phone number: _____

Student's medical specialist/phone number: _____

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(s), or, in the event the designated preferred practitioner is no 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 _____

Part II - Refusal of treatment

(Do not complete Part II if you have 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 take the following actions:

Signature of parent/guardian _____ Date _____