

**EMERGENCY MEDICAL AUTHORIZATION
NORTH OLMSTED CITY SCHOOLS**

20__-20__

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

STUDENT: _____ **GRADE:** _____

ADDRESS: _____ **TELEPHONE:** _____

SECTION A

PARENTS NAME _____ **PHONE (H)** _____
PHONE (W) _____

SECOND PARENT _____ **PHONE (H)** _____
PHONE (W) _____

ADDITIONAL NUMBERS TO REACH PARENTS: _____

SECTION B: OTHER EMERGENCY CONTACTS (Those willing to assume responsibility)

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

Are you allergic to any drugs? _____ If so, what? _____
Do you have any allergies? (i.e.. Bee sting, dust, etc.) _____
Do you suffer from asthma, diabetes or epilepsy? _____
Do you wear contacts? _____

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact either parent/guardian are not successful, I hereby **GIVE MY CONSENT FOR:**

1 (Preferred Physician) Dr. _____ Phone: _____

(Preferred Dentist) Dr. _____ Phone: _____

Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist and,

2 Transfer of my Student to _____ (preferred hospital) or any hospital that is reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed. Are there any other facts concerning the students medical history or physical impairments to which a physician should be alerted?

PARENT'S SIGNATURE: _____ DATE: _____

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 want the school authorities to **TAKE NO ACTION** and to follow this procedure:

PARENT'S SIGNATURE: _____ DATE: _____