EMERGENCY MEDICAL AUTHORIZATION

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. **Please use Blue or Black Ink.**

Student Name_____ Student ID_____ Male_____ Female_____

Address_____ Zip_____ School_____

Home Phone_____ DOB_____ Grade_____ Homeroom_____

Father's Name_____ Cell/Work_____

Address (if different from student)_____ Home Phone_____

Email Address_____ Work Phone_____

Step-Mother's Name_____ Cell/Work_____

Mother's Name_____ Cell/Work_____

Address (if different from student)_____ Home Phone_____

Email Address_____ Work Phone_____

Step-Father's Name_____ Cell/Work_____

Guardian's Name_____ Cell/Work_____

(if other than parents)

Email Address_____ Work Phone_____

Person(s) who may be notified and to whom your child may be released if school cannot reach you:

1._____ Relationship_____ Phone_____

2._____ Relationship_____ Phone_____

3._____ Relationship_____ Phone_____

Facts concerning the child's medical history including allergies, medications taken on a daily or frequent basis, and any physical impairments to which a physician should be alerted: (Health alerts related to dietary concerns must be communicated directly to Lakota Local School Office of Child Nutrition: 6947 Yankee Rd., Liberty Township, OH 45044 (513) 644-1163, by the parent or guardian.)

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The Registered Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called_____ Phone_____

Dentist to be called_____ Phone_____

Preferred local hospital_____

Part 1-TO GRANT CONSENT **Please sign either Part 1 or Part 2 but not both**

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 reasonable 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 prior to the performance of such surgery.

Date_____ Signature of Parent/Guardian_____

Part 2-TO REFUSE 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 NO action or to: _____

Date_____ Signature of Custodial Parent/Guardian_____