

# EMERGENCY MEDICAL AUTHORIZATION

## East Liverpool City School District

**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 Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_

**School attended:** \_\_\_\_\_

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**PART I or PART II (page 2) MUST BE COMPLETED**

### Part I - To Grant Consent

**Residential Parent or Guardian:**

**Mother:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Father:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Other Name:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Name of relative or childcare provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

In the event reasonable attempts to contact me at the phone numbers listed above have been unsuccessful, I hereby give my consent for: (1) the transfer of the child to the designated hospital or any hospital reasonably accessible; and (2) the administration of any treatment deemed necessary by the medical practitioners listed below, or in the event the designated preferred practitioner is not available, by another licensed physician, dentist or medical specialist.

I hereby give consent for the following preferred medical care providers and local hospital to be called:

**Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Specialist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Local Hospital:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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 before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Address)

Please turn page over

**Do Not Complete Part II if you 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:

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\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Address)