

**AVON LAKE CITY SCHOOLS – EMERGENCY MEDICAL AUTHORIZATION**

Please PRINT or TYPE all information

Date \_\_\_/\_\_\_/\_\_\_

Student's Last Name \_\_\_\_\_ First \_\_\_\_\_



\_\_\_\_\_ Please check here if the following address or phone number is different than last year

Address \_\_\_\_\_

School (check one) Eastview \_\_\_  
Erievue \_\_\_ Redwood \_\_\_ Westview \_\_\_  
Troy \_\_\_ Learwood \_\_\_ ALHS \_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_ Approximate Ht. \_\_\_\_\_ Approximate Wt. \_\_\_\_\_

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 cannot be reached.

**PLEASE LIST CURRENT PHONE NUMBERS; PREVIOUS NUMBERS WILL BE DELETED.**

Mother's Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Additional Contact Name \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_

Name of Relative/Child Care Provider \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_

**PLEASE COMPLETE EITHER PART I OR PART II**

**PART I: TO GRANT CONSENT** -- I hereby GIVE consent for the following medical care providers and hospitals to be called:

Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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 doctors, 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.

Please list any facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted. Please contact nursing staff for all health conditions that will require attention by school personnel.

\_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

**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:

\_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Student's Last Name \_\_\_\_\_