

AVON LAKE CITY SCHOOLS – EMERGENCY MEDICAL AUTHORIZATION FORM

Please PRINT or TYPE all information

Date / /

Student's Last Name _____

First _____



Please check here if the following address or phone number are different from 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