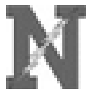
Emergency Medical Authorization



Northmont City Schools

4001 Old Salem Road
Englewood, Ohio 45322

167,100
05/05

Grade ______ Elem Home room/ MS Target HS 1st period Teacher ______ Student Name ______

Date of birth ______ Address ______ City ______ Zip ______

School Attends ______ Home Telephone ______ Cell Phone ______ pager number ______

Purpose - To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority, when parent or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name ______ Daytime Phone ______ Cell/Pager______

Father's Name ______ Daytime Phone ______ Cell/Pager______

Other's Name ______ Daytime Phone ______ Cell/Pager______

Emergency contact (other than parent)

Name ______ Relationship ______

Address ______ Telephone______ Cell/Pager______

PART I OR II MUST BE COMPLETED

PART I - 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:

______

Signature of Custodial Parent   Address of Custodial Parent   Date

PART II - TO GRANT CONSENT   **(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)**

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

Doctor ______ Telephone ______

Dentist ______ Telephone ______

Medical Specialist ______ Telephone ______

Local Hospital ______ Emergency Room 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 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 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.

Circle if your child has: Heart Disease   Tuberculosis   Epilepsy   Asthma   Diabetes

Explain any allergy or disease causing difficulty:

______

Medication taken regularly:

______

Signature of Custodial Parent   Address of Custodial Parent   Date