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___ Erieview___ 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**_____

10/20/2010

Student's Last Name_____