

WILLARD
CITY SCHOOL DISTRICT
955 SOUTH MAIN STREET
P.O. BOX 150
WILLARD, OH 44890-0159

Student Name _____
First Middle Last

EMERGENCY MEDICAL AUTHORIZATION FORM

Address _____
Student Social Security Number _____ Zip _____
Date of Birth _____ Telephone _____
Gender _____ Grade _____ School _____ Teacher _____

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 or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone _____
First Last Place of Employment _____
Father's Name _____ Daytime Phone _____
First Last Place of Employment _____
Guardian's Name _____ Daytime Phone _____
First Last Place of Employment _____
Child Care Provider _____ Daytime Phone _____
First Last Place of Employment _____

In case parent or guardian cannot be contacted, name of person to be notified:

_____ Relationship _____
Address _____ Daytime Phone _____
_____ Zip _____

(SEE REVERSE SIDE)

Physician _____ Phone (____) _____
Dentist _____ Phone(____) _____
Medical Specialist _____ Phone (____) _____
Area Hospital _____ Phone (____) _____
Insurance Company _____ Insurance # _____

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

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by the 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 reasonable accessible.

This authorization does not cover major surgery unless 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.

I hereby give consent for the above medical providers and area hospital to be called:

Date _____ Signature of Parent/Guardian _____
Address _____
Zip _____

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 _____
Address _____
Zip _____