

WEST GEAUGA LOCAL SCHOOL DISTRICT**EMERGENCY MEDICAL AUTHORIZATION**

8615 Cedar Road, Chesterland, OH 44026

Fax: High School – 440-729-5959 / Middle School – 440-729-5909 / Lindsey – 440-729-5989 / Westwood - 440-729-5924

2016-2017Purpose: This form is to be completed by the parent/guardian to authorize the provision of emergency treatment for children who become ill or injured while under the school authority, when the parent(s) / guardian(s) cannot be reached.

Student Name: _____ School: _____ Grade: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____

PARENT / GUARDIAN INFORMATION: (Please Print) Emergency Contact #1 Mother/Guardian: _____ Daytime Phone: _____

Cell: _____ Email: _____

 Emergency Contact #2 Father/Guardian: _____ Daytime Phone: _____

Cell: _____ Email: _____

 Emergency Contact #3 Name: _____ Relationship: _____

Contact Number: _____ Alternate Number: _____

PART I OR II MUST BE COMPLETED **PART I – TO GRANT CONSENT**

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

Doctor: _____ Dentist: _____ Specialist: _____

Phone: (____) _____ Phone: (____) _____ Phone: (____) _____

Local Hospital: _____ Phone: (____) _____

Facts concerning the child's medical history including allergies: _____

Medications being taken or physical impairments to which a physician should be alerted:_____

_____*In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named medical care providers, or, in the event the above-named medical care providers are 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.*

Signature of Parent/Guardian: _____ Date: _____

 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 actions:

ACTION TO BE TAKEN: _____

Signature of Parent/Guardian _____

Date / / _____

Revised: 08//2016