Print Form

**WEST GEAUGA LOCAL SCHOOL DISTRICT**
**8615** Cedar Road, Chesterland, OH 44026
Phone: (440) 729-5900 Fax: (440) 729-5939

# EMERGENCY MEDICAL AUTHORIZATION

Purpose: 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:** _____

**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 05//06/2011