

Bay Village City Schools Emergency Medical Authorization Form
Please Print All Information

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.

Grade _____

Student Name _____ **Home Phone** _____

Residential Parent or Guardian Address _____

Mother's Name _____ **Work #** _____ **Cell #** _____

Father's Name _____ **Work #** _____ **Cell #** _____

Other's Name _____ **Daytime Phone** _____ **Cell #** _____

Name of Relative or Childcare Provider _____

Relationship _____ **Address** _____ **Phone** _____

List the names of two local relatives/neighbors who may be called in case of an emergency or illness when parents cannot be reached. DO NOT INCLUDE PEOPLE WHO WORK DURING THE DAY.

NAME _____ **Phone** _____

NAME _____ **Phone** _____

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

Health Concerns: _____

Allergies: _____

Medications: _____

Signature of Parent or Guardian _____ **Date** _____

Print Name _____

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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 _____ 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 doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent or Guardian _____ Date _____

Print Name _____

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:

Signature of Parent or Guardian _____ Date _____

Print Name _____

SEE OTHER SIDE