West Carrollton Schools Emergency Medical Authorization Form

Please press firmly on a hard surface with ball point pen.

Bus # _____

School _____ Student Name _____

Teacher _____ Grade _____ Address _____

Social Security Number _____ _____ Zip _____

Date of Birth _____ Telephone(____)_____

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.

Resident Parent or Guardian

Mother's Name _____ (First / Last) Work Phone (___)_____ Cell Phone (___)_____

Father's Name _____ (First / Last) Work Phone (___)_____ Cell Phone (___)_____

Other's Name _____ (First / Last) Daytime Phone(___)_____

E-Mail Address _____ (Mother/Other) _____ (Father/Other)

Name of Alternate Contact Person (Name of person to be called if parent or guardian cannot be contacted)

_____ Relationship _____

Address _____ Daytime Phone (___)_____

_____ Zip _____

Part I: To Grant Consent

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

Physician _____ Phone (___)_____

Dentist _____ Phone (___)_____

Medical Specialist _____ Phone (___)_____

Local Hospital _____ Emergency Room 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.

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

_____

_____

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 _____