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. Please be advised that those listed on this form are able to transport the student from the school as necessary. Updated 9/18/17

EMERGENCY MEDICAL AUTHORIZATION
WEST HOLMES LOCAL SCHOOL DISTRICT

School:_____ Student Name_____

Grade/Teacher _____ Address of Residence_____

Student Birthdate_____ Additional Mailing_____

Email Address_____ Home Telephone_____

AM Bus #_____/Walk/Brought to School PM Bus #_____/Walk/Picked up at School

Current Custody papers MUST be on file. Student lives with: Both____ Mom____ Dad____ Shared____ Other____

Please give information for mother
Check if this is the Residential Parent _____
Check if this address is the same as the student ____
Name_____
Address _____
Daytime #_____
Cell #_____
Employer_____
Work #_____

Please give information for father
Check if this is the Residential Parent _____
Check if this address is the same as the student ____
Name_____
Address _____
Daytime #_____
Cell #_____
Employer_____
Work #_____

We will call all numbers regarding an unreported absent student.

Please give information for: Step-Father or Guardian
Name_____
Address _____
Daytime #_____
Cell #_____
Employer_____
Work #_____

Please give information for: Step-Mother or Guardian
Name_____
Address _____
Daytime #_____
Cell #_____
Employer_____
Work #_____

We will call all numbers regarding an unreported absent student.

Are either parent in the household a member of the military? Active_____ Reserve_____ No_____

Please list family members also attending West Holmes Local Schools:

First and Last Name	Grade	Building Attending

➔**FLIP OVER-more information needed**➔

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. Please be advised that those listed on this form are able to transport the student from the school as necessary. Updated 9/18/17

PART 1 **OR** 2 MUST BE COMPLETED

PART 1 – TO GRANT CONSENT

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

Doctor to be called_____ Phone_____

Dentist to be called_____ 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 the above-named doctor 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 (2) 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_____

OR

PART 2-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_____

Additional Contact Information for those who have authority to make decisions in an emergency situation involving this student:

Additional Contact_____ Relationship to Child_____

Address_____Phone_____

Additional Contact_____ Relationship to Child_____

Address_____Phone_____