

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 3-17-14

**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.

Please list family members also attending West Holmes Local Schools:

First and Last Name	Grade	Building Attending

➔ FLIP OVER-more information needed ➔

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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 _____