Crestline Exempted Village School District

Emergency Medical Authorization

Student's Name_____ School Year 20____to 20____
Last First M.I.

Address_____ Grade_____

_____

Parents/Guardians_____ Home Phone_____

Cell Phone_____

Emergency Contact_____ Home Phone_____

Cell Phone_____

Facts concerning the child's medical history:

Medications taken regualry_____

Known allergies: Medicine_____Food_____

Other allergies:_____

Surgeries:_____

Other health concerns:_____

PART 1 or 2 MUST BE FILLED OUT

Part 1 – To Grant Consent

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

Family Doctor: _____ Phone: _____

Eye Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts have been made to contact me have been unsuccessful, I hereby give my full consent for (1) administration of any treatment deemed necessary, 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 the preferred hospital or a hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature:_____ Date:_____

Part 2 – Refusal to Consent

Do Not Complete Part 2 If You Completed Part 1

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: _____ Date:_____