

St. Clairsville-Richland City School District
Emergency Medical Authorization

(Please Print)

Student Name _____ School _____

Address _____ Telephone _____

Grade _____

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.

Residential Parent or Guardian:

Mother _____ Daytime Phone _____

Father _____ Daytime Phone _____

Other Name _____ Daytime Phone _____

Name of Relative or Childcare Provider _____

Relationship _____ Daytime Phone _____

Address _____

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 _____ 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 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 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 impairment to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____

Address _____

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 _____