

Strongsville City Schools
Athletic Department
EMERGENCY MEDICAL AUTHORIZATION
2018-2019

Purpose: To enable parents to authorize or otherwise direct emergency treatment for children who become ill or injured under school authority when parents cannot be reached. Please print clearly, using no abbreviations or nicknames. Thank you.

Completed form must be on file prior to the first day of school

Student Name: _____ Year of Graduation: _____

Address: _____ City/State: _____

Zip Code: _____ Home Phone: _____

Residential Parent or Guardian:

Mother: _____ Cell Phone: _____

Father: _____ Cell Phone: _____

Other: _____ Cell Phone: _____

Relative or other caregiver authorized to be called (in case of emergency) if parent/guardian cannot be reached:

Name: _____ Relationship: _____

Phone #: _____

Part I or II below must be completed

Part I. To Grant Consent

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

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Specialist: _____ Phone #: _____

Local Hospital: _____ Phone #: _____

Insurance Provider: _____ Policy #: _____

In the event that reasonable attempts to contact a parent, primary guardian or authorized caregiver have been unsuccessful, I hereby give my consent for 1) the administration of an treatment deemed necessary by the above named doctors, or in the event the designated preferred practitioner is not available, by any other licensed professional, and 2) the transfer of my child to an hospital reasonably accessible. This authorization does not grant consent for major surgery unless the medical opinion of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of any surgical treatment.

Facts concerning my child's medical history, including allergies, medications being taken, and any phycials impairments to which a phycisian should be aware, include: _____

Signature of Parent/Guardian: _____ Date: _____

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 medical treatment, I wish the school authorities to take no action, or to: _____

Parent/Guardian Signature: _____ Date: _____