

**Mt. Healthy City Schools
EMERGENCY MEDICAL AUTHORIZATION**

Student Name _____	Student Id# _____	Grade _____	Building _____
Street Address _____	Zip Code _____	Teacher _____	
Telephone _____	Social Security # _____	Date Of Birth _____	

PURPOSE: To enable parent/guardian to authorize who is permitted to be called when a student becomes ill or injured while at school and who permitted to transport the student home if the student is unable to remain at school and /or needs medical care.

A. Residential Parent or Guardian – PLEASE FILL OUT ALL CONTACTS IF POSSIBLE

Parent/ Guardian Contact #1 _____	Home # _____	Work # _____	Cell # _____
Contact #2 _____ (Relationship)	Home # _____	Work # _____	Cell # _____
Contact #3 _____ (Relationship)	Home # _____	Work # _____	Cell # _____

B. Name of Relative or Childcare Provider:

Name _____	Relationship _____
Address _____	Phone # _____

PART I or PART II must be completed and SIGNED

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

Doctor's Name _____	Phone # _____
Dentist's Name _____	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 impairments to which a physician should be alerted:

This health information will be shared with school personnel that have a legitimate and/or educational need to know. If there is any information that you wish to remain confidential, please do not list on this form. Any Confidential information should be listed on an attached sheet.

Attached No attached sheets

Date: _____ Signature of Parent/Guardian _____

Do not complete Part II if you have completed Part I

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 _____