

927 O’Bannonville Road, Loveland, OH 45140

Phone: 513-683-4757 Fax: 513-697-4191

**EMERGENCY MEDICAL AUTHORIZATION**

Student Name

Address

Telephone

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

*Part I or Part II must be completed.*

**Part I (TO GRANT REQUEST)**

If reasonable attempts to contact me at (phone #) or \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(other parent) at (phone #) have been unsuccessful, I hereby give my consent for:

 (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(physician) or Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred dentist) 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(preferred hospital) or any 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 before surgery is performed.

**Facts concerning the child’s medical history:**

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergy Action Plan? Yes / No**

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**Medications/dosage being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Physical Conditions/Info to which physician should be alerted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date Signature of Parent**

 **Address**

**(Part I continued on page 2)**

**(Part I - Continued)**

**Please Complete the Following:**

Name of Physician or Clinic Phone Number

Address Zip

Name of Dentist Phone Number

Address Zip

**Please contact/My child may be released to the following if I cannot be reached in an emergency:**

**1.**

 Name Address

 Relationship to Child Phone

**2.**

 Name Address

 Relationship to Child Phone

**3.**

 Name Address

 Relationship to Child Phone

DO NOT COMPLETE PART II IF YOU 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 medical treatment, I wish the school authorities to take no action or to:

Date Signature of Parent

 Address