



EMERGENCY MEDICAL AUTHORIZATION

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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. **Please use Blue or Black Ink.**

Student Name _____ **Student ID** _____ **Male** _____ **Female** _____
Address _____ **Zip** _____ **School** _____
Home Phone _____ **DOB** _____ **Grade** _____ **Homeroom** _____

Father's Name _____	Cell/Work _____
Address (if different from student) _____	Home Phone _____
Email Address _____	Work Phone _____
Step-Mother's Name _____	Cell/Work _____

Mother's Name _____	Cell/Work _____
Address (if different from student) _____	Home Phone _____
Email Address _____	Work Phone _____
Step-Father's Name _____	Cell/Work _____

Guardian's Name _____	Cell/Work _____
(if other than parents)	
Email Address _____	Work Phone _____

Person(s) who may be notified and to whom your child may be released if school cannot reach you:

1. _____	Relationship _____	Phone _____
2. _____	Relationship _____	Phone _____
3. _____	Relationship _____	Phone _____

Facts concerning the child's medical history including allergies, medications taken on a daily or frequent basis, and any physical impairments to which a physician should be alerted: (Health alerts related to dietary concerns must be communicated directly to Lakota Local School Office of Child Nutrition: 6947 Yankee Rd., Liberty Township, OH 45044 (513) 644-1163, by the parent or guardian.)

The Registered Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called _____ **Phone** _____

Dentist to be called _____ **Phone** _____

Preferred local hospital _____

Part 1-TO GRANT CONSENT

Please sign either Part 1 or Part 2 but not both

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 reasonable accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date _____ **Signature of Parent/Guardian** _____

Part 2-TO REFUSE 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 NO action or to: _____

Date _____ **Signature of Custodial Parent/Guardian** _____