NEW RICHMOND EXEMPTED VILLAGE SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

Student Name ______________________________ School Year ______________
Address ____
SS # ______________________ Birthdate _______________ Age _______
School ______________________________ Grade ______________

The purpose of this form is to authorize emergency treatment for children who become ill or are injured while under school jurisdiction and parent/guardian cannot be reached. If student does **NOT** live with both natural parents, indicate custodial parent with *.

Mother ______________________ Phones: (H) __________ (W) __________
Father ______________________ Phones: (H) __________ (W) __________
Other Adult ______________________ Phones: (H) __________ (W) __________
Relative or Childcare Provider ______________________ Phone __________

PART I OR II MUST BE COMPLETED

PART I – To Grant Consent

I give my consent for the following medical care providers to be called:

Doctor ______________________________ Phone ______________
Dentist ______________________________ Phone ______________
Other ______________________________ Phone ______________
Hospital ______________________________ Phone ______________

In the event that reasonable attempts to contact me have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my 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 my child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Parent/Guardian ______________________________ Date ______________

PART II – Refusal to Grant 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:

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Parent/Guardian ______________________________ Date ______________

Distribution: White – Clinic Yellow – Office Pink - Teacher