

**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:

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:

Parent/Guardian _____ Date _____

Distribution: White – Clinic Yellow – Office Pink - Teacher