

School _____

Date _____

Norwood City School District
Emergency Medical Authorization Form O.P.C.3313.712
2006/2007 School Year

The purpose of this form is to enable parents/guardians to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when parents or guardians cannot be reached.

Student Name _____ Address _____

Home Phone _____ Date of Birth _____ Grade _____

Daytime phone _____ Cell/Pager _____

Signature: Parent/Guardian _____

EMERGENCY INFORMATION

List in order how contacts are to be made in the event of an emergency, discipline, attendance, etc. Parents, please don't forget to include yourself in the list of emergency contacts. (Include work phone)

CONTACT 1	CONTACT 2	CONTACT 3
Name _____	Name _____	Name _____
Relationship _____	Relationship _____	Relationship _____
Day/Work Phone _____	Day/Work Phone _____	Day/Work Phone _____
Cell Phone/Pager _____	Cell Phone/Pager _____	Cell Phone/Pager _____
Address _____	Address _____	Address _____

PART I OR II MUST BE COMPLETED

Part I to Grant Consent

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Insurance _____

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 by another licensed physician or dentist (providing the designated physician or dentist is not available); 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 dentist, 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 information may be shared with school personnel if it is pertinent to my child's health and safety, educational progress, and/or behavioral management plan.

Signature: Parent/Guardian _____ Date: _____

Address: _____

Part II to Not Grant Consent

I DO NOT GIVE CONSENT for emergency medical treatment for my child. In the event of illness or in the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

Signature: Parent/Guardian _____ Date: _____

Address _____