



Norwood City School District



2006-07 School Year

STAFF EMERGENCY MEDICAL AUTHORIZATION

School Building _____ School Address _____

Employee Name _____ Date of Birth _____

Home Address _____

City, State _____ Zip code _____

Home Phone _____ Cell Phone _____

Emergency Contacts

Contact _____ Contact _____

Relationship _____ Relationship _____

Daytime Phone _____ Daytime Phone _____

Cell Phone _____ Cell Phone _____

Medical Information

Doctor _____ Phone _____

Dentist _____ Phone _____

Specialist _____ Phone _____

Preferred Hospital _____

Allergies _____

Medical Conditions _____

Medications _____

Other Medical Information _____

I hereby give my consent in the event that all reasonable attempts to contact my emergency contacts have been unsuccessful for:

- (1) The administration of any treatment deemed necessary by my above named Doctor or Dentist or in the event that the preferred physician is not available, by another licensed physician or dentist, or paramedic unit, and
- (2) My transfer to the above noted preferred hospital or any hospital reasonably accessible.

Date _____ Signature _____