

EMERGENCY MEDICAL AUTHORIZATION FORM

RIDGEWOOD SCHOOL
2420 ST. PARIS PIKE
SPRINGFIELD, OHIO 45504
937 399-8900

STUDENT NAME _____

ADDRESS _____

CITY _____ ZIP _____

TELEPHONE (_____) _____

CELL PHONE (_____) _____

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.

RESIDENTIAL PARENT OF GUARDIAN:

MOTHER'S NAME _____ DAYTIME PHONE (_ _) _____

CELL PHONE (____) _____

FATHER'S NAME _____ DAYTIME PHONE (_ _) _____

CELL PHONE (____) _____

OTHER'S NAME _____ DAYTIME PHONE (_____) _____

NAME OF RELATIVE OR CHILD CARE PROVIDER:

_____ RELATIONSHIP _____

ADDRESS _____ DAYTIME PHONE (_____) _____

CITY _____ ZIP _____

PART I OR II MUST BE COMPLETED

(See reverse side)

PART I: TO GRANT CONSENT:

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

Physician _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Medical Specialist _____ Phone (_____) _____

Local Hospital _____ Phone (_____) _____

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 doctors, 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 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 the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____

Address _____

City _____ Zip _____

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PART II: REFUSAL TO 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:

Date _____ Signature of Parent/Guardian _____

Address _____

City _____ Zip _____