Tallmadge City Schools

Emergency Medical Authorization

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.

Student Name: _____ Birth Date: _____

Street Address: _____ Grade Level: _____

City: _____ State: _____ Zip: _____ Date of Last Tetanus Shot: _____

Student Lives with (check all that apply): ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Guardian ☐ Grandparent

List below the names (first and last) of those persons who have authority to make decisions in an emergency situation involving this student. Then, indicate in the box to the left the order in which contact attempts should be made based on availability (i.e. 1st, 2nd):

☐ **Mother**: _____
Home #: _____
Cell#: _____
Work #: _____
E-mail: _____

☐ **Step-Parent**: _____
Home #: _____
Cell#: _____
Work #: _____
E-mail: _____

☐ **Father**: _____
Home #: _____
Cell#: _____
Work #: _____
E-mail: _____

☐ **Relative or Alternate**: _____
Relationship to Child: _____
Home #: _____
Cell#: _____
Work #: _____

☐ **Guardian**: _____
Home #: _____
Cell#: _____
Work #: _____
E-mail: _____

☐ **Relative or Alternate**: _____
Relationship to Child: _____
Home #: _____
Cell#: _____
Work #: _____

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications taken, and any physical impairment of which a physician and/or school personnel should be alerted? (Continue on reverse side if necessary)

_____

_____

**** COMPLETE *ONLY ONE* OF THE FOLLOWING SECTIONS ****

1. CONSENT FOR TREATMENT

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

Preferred Physician: _____ Address: _____ Phone: _____

Preferred Dentist: _____ Address: _____ Phone: _____

Specialist (Surgeon, etc.): _____ Specialty: _____ Phone: _____

Preferred Hospital: _____ Emergency #: _____

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 the preferred doctor indicated, 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.

Parent/Guardian Signature: _____ Date: _____

2. REFUSAL OF 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 actions: _____

_____

Parent/Guardian Signature: _____ Date: _____