EMERGENCY MEDICAL AUTHORIZATION AND TRANSPORTATION

Cincinnati Hebrew Day School
(513) 351-7777
(513) 351-7794 (fax)

Student Name_____ Home phone: _____

Work/Cell Phone: _____ (father) _____ (mother)

Purpose of this form - To enable parents to authorize emergency treatment and/or transportation for children who become ill or injured while under school authority, when parents cannot be reached.

Part I (TO GRANT REQUEST)

In the event that the school was unable to contact me at the above numbers, I hereby give my consent for:

(I) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

Doctor Address: _____ Doctor Phone #: _____

Dentist Address: _____ Dentist Phone # _____

(2) The transfer by car or ambulance of the child to _____ (preferred hospital) or 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 before surgery is performed.

Please note important 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

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 medical treatment, I wish the school authorities to take no action, or to

_____ _____
DATE SIGNATURE OF PARENT